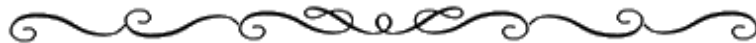


**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
New Jersey  
MCH Block Grant**

**Application for 2016  
Due July 2015**



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## **I. General Requirements**

The New Jersey Title V MCH Block Grant Application/Annual Report was developed according to the seventh edition of the Title V MCH Block Grant to States Application/Annual Report Guidance which consists of two documents: 1) Guidance And Forms For The Title V Application/Annual Report; and 2) Appendix of Supporting Documents, which includes background program information and other technical resources.

As with previous editions, this Guidance adheres to the specific statutory requirements outlined in Sections 501 and 503-509 of the Title V legislation and promotes the use of evidence-based public health practices by states/jurisdictions in developing a Five-Year Action Plan that addresses identified MCH priority needs. The revised Guidance also reaffirms the mission of Title V as “to improve the health and well-being of all of America’s mothers, children, and families.”

### **1. D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "Guidance And Forms For The Title V Application/Annual Report," Omb No: 0915-0172; expires January 31, 2017.

### **1.E. Application/Annual Report Executive Summary**

An Executive Summary will be submitted with the final Application/Annual Report. For each of the six identified population health domains, the Executive Summary presents a brief description of the Title V program’s major accomplishments and significant challenges relative to the cited State Priority Needs and the state’s annual performance on the NOMs, NPMS, SPMs and ESMs that are specific to that population health domain. A tabular representation of the Executive Summary appears in Appendix 2.

## II. Components of the Application/Annual Report

### II.A. State Overview

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually to the [Maternal Child Health Bureau](#) (MCHB), provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey. The [Division of Family Health Services](#) (FHS) in the New Jersey Department of Health (NJDOH), Public Health Services Branch posts a draft of the MCH Block Grant Application and Annual Report narrative to its website in the second quarter of each calendar year to receive feedback from the maternal and child health community.

The mission of the [Division of Family Health Services \(FHS\)](#) is to improve the health, safety, and well-being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state in the nation with 8.9 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2013 [New Jersey Population Estimates](#), 73.4% of the population was white, 14.7% was black, 9.2% was Asian, 0.6% was American Indian and Alaska Native, and 1.9% reported two or more races. In terms of ethnicity, 18.9% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2012, 26.8% of mothers delivering infants in New Jersey were Hispanic, 44.6% were white non-Hispanic, 15.3% were black non-Hispanic, and 10.9% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDOH. The Division of FHS, the [Title V agency](#) in New Jersey, has identified 1) improving access to health services thru partnerships and collaboration, 2) reducing disparities in health outcomes across the life span, and 3) increasing cultural competency of services as three priority goals for the MCH population. These goals are consistent with the [Life Course Perspective](#) which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person's life and across generations, to good health and well-being.

The selection of the New Jersey's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, and the collaborative process with other MCH partners, FHS has selected the following State Priority Needs (see Section II.C. State Selected Priorities):

- #1) Increasing Healthy Births,
- #2) Improving Nutrition & Physical Activity,
- #3) Reducing Black Infant Mortality,
- #4) Promoting Youth Development,
- #5) Improving Access to Quality Care for CYSHCN,
- #6) Reducing Teen Pregnancy,
- #7) Improving & Integrating Information Systems, and
- #8) Smoking Prevention.

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports. Consistent with federal guidelines from the MCH Bureau, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services. The following is a brief overview of MCH services to put into context the Title V program within the State's health care delivery environment.

The Improving Pregnancy Outcomes (IPO) Initiative grants were awarded in 2014 by Reproductive and Perinatal Health Services (RPHS) through a request for proposals (RFP) process. The IPO Initiative which promotes a Life Course perspective targets limited public health resources to communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Community Health Workers (CHW) and Central Intake (CI), the IPO Initiative will work to improve maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

The Community Health Worker (CHW) model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate care. The second model is Central Intake (CI) which is a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. Central Intake works closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – single point of entry and client tracking).

New Jersey was awarded the opportunity in 2014 to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes (NGA IBO) Initiative. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators.

In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM ColIN) sponsored by the MCH Bureau with technical assistance from the National Institute for Children's Health Quality. IM ColIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to improve birth outcomes. The IM ColIN State Team from NJ identified two priority areas - improving postpartum rates and smoking cessation. The NGA IBO Initiative workgroups will continue as the IM ColIN Strategy Teams to develop recommendations for improving birth outcomes and preventing infant mortality.

Another program promoting the Life Course Perspective is the Maternal and Infant Early Child Home Visiting ([MIECHV](#)) Program which has expanded Home Visiting across all 21 NJ counties with 5,339 families participating in HV during SFY 2013 (7/1/2013 to 6/30/2014). The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF). NJ is a recipient of both a federal MIECHV Formula and Competitive grant.

The Child and Adolescent Health Program (CAHP) successfully applied in 2010 for two new federal grants to prevent teen pregnancy and promote youth development. The NJ Personal Responsibility Education Program (NJ PREP) is a school- and community-based comprehensive sexual health education program that replicates evidence-based and medically accurate programs proven effective in reducing sexual risk behaviors such as unprotected sex, or in encouraging safer ones, such as abstinence, using condoms and other methods of practicing safer sex. NJ PREP also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. The goal of the second program, New Jersey Abstinence Education Program (NJ AEP), is to provide 10- to 14-year-old adolescents with the knowledge and skills to abstain from or delay the initiation of sexual activity. At least 50% of these youth live in one of the 30 state-identified, high-risk NJ municipalities. NJ AEP helps teens make healthy decisions and positive choices to meet their future life goals. NJ AEP has been implemented in eight NJ counties including in 60 public schools, and in nine community-based and 11 faith-based settings, reaching more than 8,000 10- to 14-year-olds annually.

To address the obesity epidemic, the [ShapingNJ Partnership](#) continues to grow, and currently boasts more than 320 organizations that have signed a formal agreement with ShapingNJ, committing to work to implement 10 obesity prevention strategies throughout the state. The goal of the ShapingNJ Partnership is to prevent obesity and improve the health of populations that are at risk for poor health outcomes in NJ by making "the healthy choice, the easy choice." The ShapingNJ Partnership has become fairly high profile, garnering quite a bit of public attention. The ShapingNJ website reaches consumers as well as professionals and partners with the latest research, information and best practices, as well as toolkits for improving health in each of the 5 settings where New Jerseyans live, work and play: child care centers, schools, communities, worksites and businesses, and healthcare settings.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated [Federally Qualified Health Centers](#) (FQHCs) since 1992 under the Federally Qualified Health Centers-Uncompensated Care Fund. In SFY 2015, the FQHC-Uncompensated Care Fund is funded at \$31 million. Recently the FQHCs added 7 new licensed ambulatory primary care sites and 2 additional sites are pending approval. In SFY 2016 the FQHC-Uncompensated Care Fund proposed funding is \$32.3 million to continue to focus on the needs of the uninsured and particularly those residents not eligible for the Patient Protection and Affordable Care Act (ACA) and/or NJ FamilyCare under Medicaid Expansion who need access to care and who meet eligibility requirements.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program (NSGS) helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. In terms of newborn screening for disorders detectable via the heelstick, all newborns receive screening for 55 disorders. On June 30, 2014 screening for Severe Combined Immunodeficiency (SCID) was implemented and by end of 2015/early 2016, implementation of screening for five lysosomal storage disorders including Krabbe, Pompe, Neimann Pick, Fabry, and Gaucher, will be implemented. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. In State Fiscal Year 2014, 99,628 newborns received initial screens and 5,826 infants had abnormal screening results. New Jersey remains among the leading states in offering the most screenings for newborns.

NSGS meets and communicates regularly with several advisory panels composed of parents, physicians, specialists, and others to ensure NJ's program is state-of-the-art in terms of screening technologies and operations and it is responsive to any current concerns regarding newborn screening.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD) took effect on August 31, 2011. Aggregate and individual level data reporting mechanisms were implemented to ensure that all eligible births are screened. Through December 2014, NJ birthing facilities

submitted quarterly aggregate screening reports. Aggregate reporting has since been discontinued with the inclusion of pulse ox screening questions in the new web-based Electronic Birth Registry System affording the capability to track individual level screening results. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry via the Pulse Oximetry Module. As of December 2014, NJDOH has received reports of 15 infants with previously unsuspected critical congenital heart defects detected through the screening program. In 2012, NJ was one of six states awarded a 3-year HRSA funded CCHD Newborn Screening Demonstration Program Grant which has enabled the development of education for parents, nurses, and physicians regarding CCHD and screening. NJDOH continues to provide technical assistance to the birthing facilities and, in partnership with the NJ NICU Collaborative, is leading a multi-state evaluation of screening practices in the NICU.

The Early Hearing Detection and Intervention Program (EHDI) monitors compliance with the NJ universal newborn hearing screening law, and measures NJ's progress in achieving the national EHDI goals of ensuring that all infants receive a hearing screening by one month of age, that children who do not pass screening receive diagnostic testing by three months of age, and that children who are diagnosed with hearing loss receive family-centered, culturally competent Early Intervention Services by six months of age. Hospitals have been very successful in ensuring that newborns receive hearing screening prior to hospital discharge, ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts.

The NJ EHDI Program is currently engaged in holding a webinar series for EHDI hospital contacts, "EHDI Chats," on topics of interest to coordinators. The first webinar was held in March 2015 and focused on strategies to improve follow-up in inner-city populations. The second was held in April 2015 and reviewed the Plan-Do-Study-Act (PDSA) model of quality improvement process and their third is scheduled for June 2015 and will discuss successfully implemented PDSAs.

NJ continues to have one of the highest rates of autism in the United States. According to the Centers for Disease Control and Prevention's (CDC) 2008 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 30, 2012, one of every 49 eight-year-olds in Union County, NJ had autism. The CDC 2010 prevalence figures have been published in the MMWR on March 28, 2014 and these figures cited NJ as having the highest prevalence rate of 21.9 per 1,000, or approximately one in 45. These most recent statistics were based on studies from four counties in NJ.

The Governor's Council for Medical Research and Treatment of Autism (the Council) is in the Office of the Commissioner at NJDOH; the Council has 14 members and is legislatively mandated. In 2012, the Council established a Center of Excellence for Autism (NJACE). The mission of the NJACE is to research, apply and advance best practices in the understanding, prevention, evaluation and treatment of autism spectrum disorders (ASDs), enhancing the lives of individuals with ASDs across their lifespans. The NJACE consists of (1) a Coordinating Center, (2) Clinical Research Program Sites, and (3) Clinical Research Pilot Projects. The NJ ACE Coordinating Center provides common management and support functions to unify the NJ ACE Clinical Research Program Sites and Pilot Project grantees, increase efficiency and reduce costs. The five-year Coordinating Center grant was awarded to Montclair State University. The first NJ ACE Program Site grant was awarded to Rutgers University and the second to the University of Medicine and Dentistry of New Jersey, also now part of Rutgers University. The NJ ACE Program Site and Pilot Project grantees will develop and conduct clinical research projects with the potential to improve the physical and/or behavioral health and well-being of individuals with ASDs. The Council is particularly interested in projects with potential direct clinical impact.

Autism Registry Staff are working with the Council and their Coordinating Center to hold regional statewide workshops for diagnosticians regarding the impact of the diagnostic criteria changes from DSM4 to DSM5.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). BDARS is an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking

registered children to health services. Since 1985, NJ has maintained a population-based birth defects registry of children with all defects. Starting in 2003, the Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects and Autism Reporting System (BDARDS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services Program.

New Jersey has been very successful in linking children registered with the BDARS with services offered through the county-based SCHS CMUs. However, the system did not further track children and families to determine if and what services were offered to any of the registered children. To address this missing information, a second module is being added to the SCHS CMUs to track and monitor services provided to the children and their families. Also included in the module is the ability to create and modify an Individualized Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

The Case Management module, also known as the Case Management Referral System (CMRS), was successfully adopted by all 21 counties and is live statewide. It provides the State Title V program with the opportunity for desk top review of referral and linkage to care. As existing cases are migrated to CMRS, and newly referred cases are entered into the database, it is anticipated that trends in access to care and outcomes will be more measurable and readily tracked. Likewise, the challenges of reconfiguring data reporting and tracking systems, as well as the training and retraining State and community-based agencies, while keeping the needs of CYSHCN and their families center to our mission is our challenge.

The Family Centered Care Services (FCCS) program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCN age birth to 21 years of age. Ultimately, services and supports provided through Special Child Health Services Case Management Units (SCHS CMUs), Family WRAP (Wisdom, Resources, and Parent to Parent), and Specialized Pediatric Services providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and federal funds administered via community health services grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Likewise, intergovernmental and interagency collaboration is ongoing among federal, State and community partners and families; i.e., Social Security Administration; NJ State Departments of Human Services' NJ FamilyCare/Medicaid programs, Catastrophic Illness in Children Relief Fund, Children and Families, Labor, Banking and Insurance, Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as the NJ Academy of Pediatrics Pediatric Council on Research and Education (NJ PCORE), NJ Hospital Association, and disability specific organizations such as the Arc of NJ, and the Statewide Parent Advocacy Network (SPAN) and the Community of Care Consortium (COCC). Consultation and collaboration with NJDOH programs such as the Birth Defects and Autism Registry, Early Intervention Services, the Ryan White Family Centered HIV Care Network, Maternal Child Health, Special Supplemental Nutrition Program for Women, Infants and Children, Primary Care/Federally Qualified Health Centers, and HIV/AIDS, STD, and Tuberculosis, as well as Public Health Infrastructure, Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families. For example, the transition of CYSHCN formerly enrolled in the Community Resources for Persons with Disabilities waiver and newly identified underinsured CYSHCN into Managed Long Term Services and Supports, the referral of uninsured transition aged youth into Medicaid expansion or the Marketplace, and support for families affected by Superstorm Sandy are accomplished through interagency collaboration and linkage with resources across agencies and systems.

Family input is centric to development and evaluation of FCCS programs. In addition to the Press Ganey surveys administered by SPSP provider agencies, in 2014, the Title V program initiated family satisfaction surveys in English and Spanish. Nearly 1,800 responses were received and 150 respondents completed their open ended questions in Spanish. Data is being cleaned and analyzed, will be shared with provider agencies, and used in review and planning for services. An example of preliminary data that will be helpful in planning services includes: 64% of parents whose children received services through the Child Evaluation Centers said that their coordination of services was excellent. Findings from the family satisfaction surveys should indicate areas for further investigation and quality improvement. Additionally, family and youth input on multi-system access to care is obtained through the COCC, a community coalition led by SPAN and comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations. COCC members and visitors meet quarterly and collaborate to improve access to share updates on federal, State, and community-based programs and services that address access to care for CYSHCN.

NJ remains successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; CECs including the Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP. With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, and monitoring of services offered and/or provided to determine client outcomes. In 2014, State Case Management staffs launched a quality improvement project to enhance consistency in documentation within individualized service plans across the SCHS CMUs, and to improve upon the Case Management Referral System's (CMRS) data gathering capability. Information garnered from this initiative is anticipated to enhance NJ's efforts to improve performance on the six core MCHB outcomes for CYSHCN.

The reorganization of State services and supports for CYSHCN by intergovernmental partners; Department of Human Services; Division of Medicaid and Health Services and Division of Developmental Disabilities; the Department of Children and Families' Divisions of Children's System of Care and Division of Family and Community Partnerships, and the Department of Health's Division of Aging and Community Services realigned pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges and benefits for families with CYSHCN to maintain and optimize access to community-based care. These exciting changes are anticipated to broaden health insurance access. NJ's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains key to ensuring that families are adequately supported during the reorganization of these systems.

In addition to the health care system changes described above, in 2012 the extremely dangerous and damaging Superstorm Sandy (SSS) affected NJ CYSHCN and their families. Significant recovery has been achieved. However, its catastrophic effects challenged our State's infrastructure and ability to maintain an integrated safety net of providers, mobilize and share resources, as well as to support evacuation, re-location and long-term recovery. It also provided opportunities for the Title V program to promote resiliency for CYSHCN and their families by providing information, training, referral and supports to families, as well as technical support to colleagues in federal, State and local agencies. Through June 30, 2015, enhanced capacity for the provision of case management and family support will continue for Sandy-impacted families of CYSHCN that reside in 10 coastal counties through Social Services Block Grant funding. Transition planning for CYSHCN is underway to ensure continuity of supports with their SCHS CMU and long-term recovery groups. These efforts will be described more fully in State Agency Coordination.

## **II.B. Five-Year Needs Assessment Summary**

### **II.B.1. Process**

The New Jersey Title V program, the Division of Family Health Services (FHS), has prepared the following Five-Year Needs Assessment Summary that identifies consistent with health status goals and national health objectives the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN). NJ has prepared this statewide Five-Year Needs Assessment Summary according to Title V guidelines.

The completion of a comprehensive needs assessment for the Maternal and Child Health (MCH) population groups is a continual process that the FHS performs in collaboration with many other organizations and partners. The needs assessment process is consistent with the conceptual framework in Figure 1 MCH Needs Assessment, Planning, Implementation, and Monitoring Process in the guidance. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the New Jersey Department of Health (NJDOH), the MCH Bureau, and other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

The goals and vision that guide the Needs Assessment originate from the mission statement of the Division of Family Health Services (FHS). Leadership for directing and completing a comprehensive needs assessment is provided by the Assistant Commissioner of FHS, Service Directors in FHS, and the Program Managers in FHS. The overall needs assessment methodology is similar for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs. Though many of the functions occur simultaneously the sequential process is described below. This is a continuous and on-going process throughout the year.

### **II.B.2. Findings**

The selection of the New Jersey's eight State Priority Needs (SPNs) is a product of FHS's continuous needs assessment. Multiple processes contribute to the overall needs assessment process including: the MCH Block Grants needs assessment process, the NJDOH budget process, Departmental strategic planning, assessment of the Healthy People 2020 objectives, the Public Health accreditation process, grant-driven needs assessments (MIECHV, Healthy Start, PREP...) and the collaborative process with other MCH partners. As a result of the overall needs assessment process, FHS has selected the following State Priority Needs for the MCH Block Grant (see Section II.C. State Selected Priorities):

SPN #1) Increasing Healthy Births,  
SPN #2) Improving Nutrition & Physical Activity,  
SPN #3) Reducing Black Infant Mortality,  
SPN #4) Promoting Youth Development Programs,  
SPN #5) Improving Access to Quality Care for CYSHCN,  
SPN #6) Reducing Teen Pregnancy,  
SPN #7) Improving & Integrating Information Systems, and  
SPN #8) Smoking Prevention.

Some of these priorities have been longstanding priorities (SPN #3 Decreasing Black Infant Mortality, SPN #6 Decreasing Teen Pregnancy, SPN #7 Improving and Integrating Information Systems, and SPN #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several areas or population groups (SPN #4 Promoting Youth Development Programs, SPN #1 Increase Healthy Births, and SPN #8 Smoking Prevention). A priority focusing attention on the more recent public health issues of obesity is SPN #2 Improving Nutrition and Physical Fitness.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following eight of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:

NPM #1 Well woman care,  
NPM #4 Breastfeeding,  
NPM #5 Safe Sleep,  
NPM #8 Physical activity,  
NPM #11 Medical Home,  
NPM #12 Transitioning to Adulthood,  
NPM #13 Oral Health, and  
NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Five existing SPMs will be kept, and two old SPMs will be deleted. The existing SPMs which will be continued are: SPM #1 Black non-Hispanic Preterm Infants in NJ, SPM #2 Children with Elevated Blood Lead Levels, SPM #3 Hearing Screening Follow-up, SPM #4 Referral from BDARS to Case Management Unit, and SPM #5 Age of Reporting Autism to the BDARS. The old SPMs to be deleted are: Regional MCH Consortia Implementing Community-based FIMR Teams and Overweight High School Students.

The table on the next 2 pages, Figure 1 Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model summarizes the selected eight NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM from Appendix B, Guidance page 9

<b>Domains</b> (set by HRSA)	<b>State Priority Needs</b> (states identify) based on Needs Assessment	<b>Strategies</b> (states identify)	<b>National Outcome Measures (NOMs)</b> (states select from list)	<b>National Performance Measures (NPMs)</b> (select 8 of 15 )	<b>Evidence-Based or –Informed Strategy Measures</b> (due for 2017)	<b>State Performance Measures (SPMs)</b> (states select)
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Infant Mortality; 2 Preterm-related death; 3 Neonatal Mortality; 5, 6, 7, 8, 21 Postpartum hospitalizations with severe morbidity; 22 Maternal Death	<b>#1 Well Women Care</b>	IM CoIIN recommendations, HEDIS measures, Central Intake referrals; Completed CHSs & PRAs DHS Pay4Performance, Linking Medicaid and VS data	
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	IPO; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; Surveillance (PRAMS, EBC)	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth; 9	<b>#5 Infant Safe Sleep</b>	Back to Sleep & safe sleep, no bed sharing, UID Review,	#1 Black preterm births
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	IPO; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth , 9	<b>#4 Breastfeeding</b>	Baby Friendly Initiative; mPINC MIECHV breastfeeding	#1 Black preterm births
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC, CDC) School Health	11 Overweight rate; 9 Kids in very good health; 13 Kids without insurance;	<b>#8 Physical activity</b>	CSH/WSCC activities; School Health Teams; School Health Index; Fitnessgram	#2 Elevated lead screening;

<b>Domains</b> (set by HRSA)	<b>State Priority Needs</b> (states identify) based on Needs Assessment	<b>Strategies</b> (states identify)	<b>National Outcome Measures (NOMs)</b> (states select from list)	<b>National Performance Measures (NPMs)</b> (select 8 of 15 )	<b>Evidence-Based or –Informed Strategy Measures</b> (due for 2017)	<b>State Performance Measures (SPMs)</b> (states select)
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	10, 11, 13, 15 Adolescent death 10-19; 16 MVA fatality 15-19 17 Suicide 15-19	<b>#11 Medical home,</b>	SCHS Case Management; ISPs; Medical Home Index	
5) CYSHCN and 4) Adolescent/ Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case management Services; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ	18 CSHNC receiving care in a well-functioning system; 19 % CSHCN & ASD; 20 Kids with a mental/behavioral condition who receive treatment, 23 Timely NBS+ follow-up	<b>#12 Transitioning to Adulthood</b>	CM level service reports;	#3 Hearing screening F/U; #4 Referred from BDARS to Case Management Unit; #5 Age reporting autism to BDARS;
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14 Kids 1-6 with cavities; 9 Kids in very good health;	<b>#13 Oral health</b>	Project REACH; Project PEDS; MIEC Home Visiting;	
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA MIEC Home Visiting SSDI, ECCS; VIP; Master Client Index Project	ALL	ALL	MIECHV Evaluation/CQI	
6) Life Course	#8 Smoking Prevention	SSDI, ECCS Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA MIEC Home Visiting	ALL	<b>#14 Household Smoking</b>	Cessation referrals; Smoking assessments (CHS & PRA); Mom's Quit Connection referrals	

As required in the first year Application/Annual Report (FY 2016/FY 2014), this section presents a focused summary of the findings of its Five-year Needs Assessment. The following table, Findings of the Five-Year Needs Assessment, provides this summary in tabular form. Highlighted in this summary are the health status of the MCH population relative to the state's noted MCH strengths/needs and the identified national MCH priority areas, organized and presented by each of the six population health domains. Also summarized are the adequacy and limitations of the NJ Title V program capacity and partnership building efforts relative to addressing the identified MCH population groups and program needs. Specific partnership and collaborative efforts are listed, along with descriptions of promotion of family/consumer engagement and leadership, coordination with other MCHB and federal, state and local MCH investments.

Findings of the Five-Year State Needs Assessment – from Appendix B, Guidance page 9

<b>Domains</b>	<b>State Priority Needs</b>	<b>Title V Capacity (strengths/needs) (adequacy/limitations)</b>	<b>Title V Partnerships Family/consumer engagement, Leadership, Coordination</b>	<b>Health Status on Pertinent NPMs and NOMs</b>
1) Maternal/ Women's Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes Initiative; IM CoIIN; MIEC Home Visiting Program; Increase postpartum visit rates; MCHCs, Central Intake, CHW	IPO County Advisory Groups IM CoIIN Workgroups MIECH Home Visiting Advisory Groups	#1 Well Women Care ↔
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW MCHCs, Central Intake, CHW	IPO County Advisory Groups IM CoIIN Workgroups MIECH Home Visiting Advisory Groups	#4 Breastfeeding ↑ #5 Safe Sleep ↑
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Coordinated SCHOOL Health/Whole School, Whole Community, Whole Child (CSH/WSCC)	CSH/WSCC Partnerships ShapingNJ partnerships	#8 Physical activity ↔
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ Adolescent Advisory Group HIV/STD/TPP Coalition	Adolescent Advisory Group	#11 Medical Home ↔ #12 Transition to Adulthood ↔
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	21 SCHS Case Management Units SPSP Services (10 CECs with 6 FAS, 5 Cleft Lip/Palate, 3 Tertiary Care); regionalized NJ Family WRAP (family support); 7 RWPD Family Centered HIV Network; NJ AAP/PCORE Medical Home Project; Superstorm Sandy Block Grant enhanced capacity for SCHS Case Management, Family WRAP, Medical Home but funding ends 6/30/15 and families and medical home initiatives need to transition	Family Satisfaction Surveys Intergovernmental collaboration with Social Security Administration and State agencies; DHS Medicaid /NJ FamilyCare, Division of Disability Services, Division of Developmental Disabilities; DCF's Children's System of Care Initiative, Perform Care, DOBI Division of Insurance; DOL Disability Determinations Unit; DOE Part B Community of Care Consortium & Special Education Advisory Taskforce; DOH Public Health Service, Health Systems, Public Health Infrastructure, Laboratories, & Emergency Preparedness; Catastrophic Illness in Children Relief Fund, NJ Council on Developmental Disabilities, Special Education Advisory Council; SPAN, Community of Care Consortium (COCC)	#11 Medical Home ↔ #12 Transition to Adulthood ↔
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; Central Intake / PRA		#13 Oral Health ↑ #15 Household Smoking ↑

## II.B.2a. MCH Population Needs

The table below, Summary of MCH Population Needs, displays the health status for each of the six population health domains according to the 8 selected NPMs. The table provides a summary of population-specific strengths/needs and identifies major health issues for each of the 6 population health domains which came from identified successes, challenges, gaps and areas of disparity identified during the needs assessment process.

*Table X - Summary of MCH Population Needs*

<b>Domains</b>	<b>State Priority Needs</b>	<b>Pertinent NPMs</b>	<b>+ Strengths / - Needs</b>	<b>Successes, challenges, gaps, disparities (major health issues)</b>
1) Maternal/ Women's Health	#1 Increasing Healthy Births	#1 Well Women Care	+Low uninsured rates, +Low preventive care use, -Late prenatal care, -Unintended pregnancy	Lack of preventive care, Late/inadequate prenatal care, Unintended pregnancy
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	#4 Breastfeeding, #5 Safe Sleep	+Baby Friendly Initiative +Revised Hospital regulations, +Strong coalitions, +SUID-CR	Formula supplementation, Unsafe sleep practices
3) Child Health	#2 Improving Nutrition & Physical Activity	#8 Physical Activity	+ShapingNJ partnerships, +CSH/WSCC School community partnerships	Built environment caloric dense foods lack of PA opportunities
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	#11 Medical Home, #14 Transitioning to Adulthood	+Advocacy groups +HIV/STD/TPP Coalition	Lack of preventive care, barriers to sharing medical information
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	#11 Medical Home, #14 Transitioning to Adulthood	+Advocacy groups	Health insurance reimbursement
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	#13 Oral Health, #15 Household Smoking	+Cessation options -Lack of provider participation	Health insurance reimbursement, Smoking relapse

## **II.B.2b. Title V Program Capacity**

### **II.B.2b.i. Organizational Structure**

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Gloria Rodriguez, Assistant Commissioner, Division of FHS.

### **II.B.2b. ii Agency Capacity**

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the [Division of Family Health Services \(FHS\)](#) is to improve the health, safety, and well-being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in NJ originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program and its screening (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following table summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services at the community level.

Figure X – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services

Domain	State Priority Needs (SPNs)	Collaborations with other state agencies and private organizations	State Support for Communities	Coordination with Community-Based Systems	Coordination of Health Services with other Services at the Community Level
1) Maternal/ Women's Health	#1 Increasing Healthy Births	IPO with DCF, MCHC, IM CoIIN with DHS	IPO Advisory Groups & CI Hubs	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	MCHC, Home Visiting with DCF & DHS, NJHA Perinatal Collaborative, IM CoIIN with DHS	IPO Advisory Groups & CI Hubs	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF, MIECHV, Healthy Start, Strong Start
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ, CSH/WSCC AHPERD, SOPHE, NJDA, DEP, JJC, DoT	CSH/WSCC grantees	FQHCs CSH/WSCC	School Health, Child Care Coordination
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	School Health with DOE, PREP AEP HIV/STD/TPP Coalition	PREP & AEP grantees; CSH/WSCC grantees	Adolescent Advisory Group; CSH/WSCC	
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	NJ AAP/PCORE Medical Home, County Base Management	SCHS Case Management Units	County-based Case Management	EIS
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	IPO with DCF HV with DCF & DHS	IPO Advisory Groups & CI Hubs	IPO with Central Intake and Community Health Workers	Central Intake with DCF

## II.B.2b.ii. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead poisoning prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the [Maternal and Child Health Consortia](#) (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

Promoting a Life Course perspective, a new request for proposals (RFP) was issued in January 2014 by RPHS and awarded last year called the Improving Pregnancy Outcomes (IPO) Initiative which targeted

limited public health resources to populations and communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Community Health Workers and Central Intake, the IPO Initiative will work to improve specific maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and/or best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

The Community Health Worker (CHW) model uses paraprofessionals to perform a combination of community outreach, home visits, group activities/workshops, and community-based supportive services to provide a source of enhanced social support and create a bridge between underserved and hard-to-reach populations and formal providers of health, social and other community services. The role of the CHW has been broadened to provide ongoing support during the preconception and inter-conception periods to promote healthy behaviors, including initial and continuous engagement with health and community services for high need women of reproductive age within target communities.

The second model is Central Intake which is a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. Central Intake works closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. A standardized screening tool (Community Health Screening) is used and referrals to programs and services are tracked in a centralized web-based system (SPECT – single point of entry and client tracking). Thirteen grants were awarded for the Community Health Worker model and seven grants were awarded for the Central Intake model.

Also focused on Increasing Healthy Births and improving pregnancy outcomes is the work of NJ as a participant in the National Governors Association Improving Birth Outcomes and the Infant Mortality CollN. NJ was awarded the opportunity to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators. Partnering departments included the Department of Children and Families, Human Services (Medicaid) and Education.

MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement and improve the system of care to promote healthy births. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of NJ FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the 3 regional MCH Consortia. NJ follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by NJ FIMR. NJ is participating with NFIMR as one of the states beta testing the new database.

The [NJ Maternal Mortality Review Team](#) is part of a longstanding commitment among healthcare professionals and other concerned citizen to reduce and prevent the number of deaths related to pregnancy and childbearing among NJ residents. A multidisciplinary review team is utilized and the primary focus of the Case Review Team is to identify systems related issues. Recommendations for systems improvement are shared with healthcare professionals and the public through the Maternal Mortality Report. Team recommendations are also used for program planning at the NJDOH.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance

use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Approximately 30% of the pregnant women in NJ were screened for substance use during the past year according to the Perinatal Risk Assessment volume numbers. The majority of these patients were seen at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 125 education programs held for over 1,458 professionals. There were 646 programs held to educate the general public and approximately 16,290 people participated.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visitation services are provided by 67 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving approximately 6,000 families in SFY 2014.

Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the law that requires screening and education at specified intervals during the perinatal period. NJDOH offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site ([www.njspeakup.gov](http://www.njspeakup.gov)) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.

The NJDOH continues to support the provision of Family Planning via a grant with the New Jersey Family Planning League to ensure that family planning services are available in all 21 counties in NJ. Family Planning agencies provide services in cooperation with other NJDOH initiatives according to [Title X national guidelines](#) including: family planning and related preventive health services, such as natural family planning methods; HIV/AIDS and sexually transmitted infections prevention and treatment; services to adolescents; cancer screening (including breast and cervical cancer); nutrition education; preconception and interconception care; infertility services; and counseling on establishing a reproductive life plan.

#### **II.B.2b.ii. Preventive and Primary Care for Children and Adolescents**

The Child and Adolescent Health Program, within MCHS, focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

An emphasis in Child Health is the prevention of lead poisoning among children under six years of age through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Poisoning Prevention (CLPP) Projects use a home visiting model to provide nurse case management and environmental investigations for children less than six years of age with confirmed elevated blood lead levels. Twelve sites throughout the State receive funding to provide monitoring of retesting of elevated blood lead levels, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLPP Projects are to promote a coordinated support system for lead poisoned children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

Services include a healthy homes assessment tool so that additional health and safety issues in the home can be identified and remediated so that homes are free of disease-causing agents and sources of preventable injuries. NJDOH has established a partnership with MIEC Home Visiting programs that provide services for pregnant women, infants, young children, in addition to resource family homes that provide a safe residential environment for children who are in the foster care system.

Child Health annually processes from laboratories approximately 200,000 blood lead screening results on children. Electronic notifications are then sent to local health departments for public health intervention of elevated blood lead levels. Child Health monitors local health departments' provision of nursing case management and environmental investigation services to ensure compliance with State regulation N.J.A.C. 8:51. Annually a report is published on the incidence and prevalence of lead poisoning in NJ.

Grants are provided to 13 local health departments, with the highest number of cases, to support the provision of nursing case management and environmental investigation services. In addition, Child Health provides grants to three agencies to administer regional coalitions, serving every county in NJ, to provide prevention-focused education and training to parents, caregivers of young children, and property owners and renters. The NJDOH co-administers the New Jersey Healthy Homes Training Center which provides training to health, social services and housing professionals. In partnership with the American Academy of Pediatrics/NJ Chapter, Child Health promotes a nationally-recognized medical home model.

Public outreach and professional education on lead poisoning prevention, using a healthy homes approach, is conducted by three Regional Lead and Healthy Homes Coalitions. From May 2012 to August 2014, a pilot using the LeadCare II point-of-care blood lead analyzer was used by self-selected local health departments. The success of the project serves as the foundation for the Superstorm Sandy recovery project's blood lead screening initiative in nine most impacted counties.

Since July 2010, Adolescent Health has been working to implement the CDC Coordinated School Health (CSH)/Whole School, Whole Community, Whole Child ([WSCC](#)) model. One Full Time Equivalent (FTE) professional staff person is assigned responsibility for this project and the position is currently vacant. The CDC model provides a framework for organizing school health into 10 components: 1) Health Education, 2) Physical Education, 3) Health Services, 4) Counseling, Psychological and Social Services, 5) Nutrition Services, 6) Staff Wellness, 7) Healthy Physical School Environment, 8) Healthy Social-Emotional School Climate and Culture, 9) Family Engagement, and 10) Community Involvement. School health programs promote healthy behaviors and health is critically linked to academic performance. Self-reported health behaviors (alcohol, tobacco and other drug (ATOD) use; healthy food choices; physical activity; sexual activity; and, violence, injury and safety) of high school youth are surveyed every other (odd numbered) year using the NJ Student Health Survey.

Three processes are integral for successful implementation of the CSH/WSCC model: 1) establish a School Health Team; 2) assess the school's health policies, programs and practices using CDC's School Health Index (SHI) assessment tool; and, 3) develop, implement and evaluate an action plan based on the results of the assessment. Coordination of these ten components identifies gaps, avoids duplication of activities and improves the efficiency and effectiveness of health programs and services available in the school system.

The current CSH regional grantee agencies, selected through a competitive application process, are responsible for the administrative oversight, training, technical assistance and resource support needed by funded or interested public schools, grades six and above in their respective northern, central or southern region. The goal of this project is to improve the health (physical, mental, emotional and social) well-being of students and school staff and strengthen the health and safety of the school environment. Currently, these regional grantee agencies fund schools to implement evidence-based or best practice school health actions.

Sustainability of healthy school practices and programs can be ensured through community

involvement, parent and youth engagement and policy. The Statewide Parent Advocacy Network (SPAN) is funded to implement "Parents as Champions (PAC) for Healthy Schools." This training empowers parents as "agents of change" to facilitate parental action in promoting healthier schools. This project also partners with various state, local and statewide professional organizations to collaborate on improving school and student health to improve their learning and consequently, their life success.

On October 1, 2013, Community Health and Wellness Services was awarded the CDC cooperative agreement DP1305 for the basic and enhanced components of "State Public Actions to Prevent Chronic Disease and Promote School Health." A staff person was recently hired and assigned to work on the school health strategy and coordination between the two service units is planned.

The CAH Program successfully applied for and was awarded two new federal grants to prevent teen pregnancy in 2010. The New Jersey Personal Responsibility Education Program (NJ PREP) enables six grantees to replicate evidence-based programs that have proven effectiveness in changing behaviors to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. NJ PREP funding also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. NJ PREP grantees implement seven evidence-based sexual health education programs: Be Proud Be Responsible; Be Proud Be Responsible Be Protective; Making Proud Choices; Reducing the Risk; SiHLE; Teen Health Project; and Teen Outreach Program. In SFY 2014, NJ PREP was successfully implemented by six sub-grantees at more than 60 locations (27 community-based organizations and 34 school-based organizations) in 24 municipalities and 12 counties throughout NJ reaching approximately 2,300 unduplicated youth participants.

The NJ Abstinence Education Program (NJ AEP) funds four grantees to provide abstinence-only education to adolescents that are at high-risk for teen pregnancy, STDs/STIs and HIV/AIDS. The NJ-AEP is a primary prevention strategy that provides 10- to 14-year-olds the knowledge and skills to avoid the high-risk behavior of early sexual activity and promotes abstinence from sexual activity and, where appropriate, provides options that may include mentoring, counseling and/or adult supervision. Grantees implementing abstinence education curriculum and positive youth development-related activities are: Institute for Relationship Intelligence, Inc. serving Bergen, Hudson and Passaic Counties; Lifeguard, Inc. serving Atlantic, Cumberland and Cape May Counties; Mount Olives Church of God Inc. serving Essex and Union Counties; and Saint Peter's University Hospital serving Middlesex and Union counties. NJ AEP is currently implemented in eight counties in NJ, in 60 public schools, and nine community-based and 11 faith-based settings, reaching more than 8,000 10- to 14-year-olds annually. NJ AEP is funded for the fifth year by the Administration for Children and Families, with a federally-required 43% match, from other sources provided by the four grantees. The addition of a part-time Program Services Specialist maximizes the output of the program which is supervised by a full-time Program Coordinator.

The website - "NJ Parent Link, New Jersey's Early Childhood, Parenting and Professional Resource Center" was launched in June 2010 as a web-based resource for consumers and professionals. The website has been designed to function as the IT gateway for all State-based services and resources, for parents and caregivers of young children, and will include direct links to all 15 executive departments, the Governor's office, the legislative and judicial branches and provide interactive parent-to-parent forums, E-serve services and professional collaborative portal features.

Community-building website features include: interactive consumer content sections; tailored subscription services; a community calendar of events; continuing education/leadership postings; a children's art gallery; an easy-to-navigate En Espanol feature and a translation service for over 50 languages. Numerous data collection and quality assurance markers are woven throughout the website's features to maximize assessment capabilities and real time opportunities for collaboration and coordination of shared goals and resources within the early childhood community. Total number of NJ Parent Link website hits from 1/1/2013 to 4/1/2015 was 725,837. In March 2015, 7,625 unique visitors accessed information from the NJ Parent Link website.

The NJDOH established the NJ Children's Oral Health Program (COHP) in 1981. The program provides a variety of interactive, age appropriate oral health education activities for children in grades pre-K through 12. The Program is regionally implemented in the twenty-one counties of the State with each region having an Oral Health Coordinator and program staff that implement oral health activities. The oral health topics addressed include: good oral hygiene, fluoride as a preventive measure, dental sealants, healthy food choices, periodontal disease, tobacco cessation, and the prevention of oral trauma. Classroom presentations include discussion, audio-visual materials, and extensive student interaction. All program activities are adaptable for children with special needs. Education initiatives are also conducted for parents, teen parents, Women, Infant, Children (WIC) clients and pregnant women. In-service and workshop programs for non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, and social workers are also conducted.

COHP developed and implemented a major initiative to improve the oral health status of first-time families in collaboration with the NJ Home Visiting Program. In efforts to address the importance of good oral health and hygiene, regular dental visits and the establishment of a dental home, the "Be a Smart Mouth-Home Visiting and Oral Health Perfect Together" was established. The overarching goal was to develop an oral health training program targeting home visitors from the three model programs (Nurse Family Partnership, Healthy Families and Parents as Teachers) in the State. Home Visiting staff provides oral health education and resources in the family visit. The integration of oral health education into Home Visiting programs allows staff to provide oral hygiene and healthy food choice instruction in addition to education about the correlation between oral and systemic health, referral for dental care services, and establishment of a dental home in efforts to reduce dental emergency room visits that result in substantial cost savings.

Other programs coordinated by COHP serve school-age children. During the 2013-2014 school year, approximately 80,000 students in high-need/risk areas received oral health/hygiene education and oral health personal care resources. and over 15,500 students participated in the voluntary school-based fluoride mouth rinse program, "Save Our Smiles." Over 3,000 kindergarten and first-grade students participated in the Project: BRUSH interactive education initiative that engaged the school and community with oral health messages throughout the year. Other key programs included "Sugar-Less Day to Prevent Tooth Decay" carried out in the 21 counties of the State with over 1,200 fourth-grade students participating. Efforts to target multidisciplinary obstetric, pediatric, medical, nursing and home visiting staff resulted in educating approximately 3,500 providers through train-the-trainer efforts to incorporate oral health care instruction in the patient and home visiting setting.

## **II.B.2b.ii. Preventive and Primary Care for Children with Special Health Care Needs**

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net which is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, as well as to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, and multiple Specialized Pediatric Services Programs (SPSP); 10 Child Evaluation Centers (CECs) of which six house Fetal Alcohol Syndrome Disorder Centers, five Cleft Lip/Palate Craniofacial Anomalies Centers of which three also provide newborn hearing screening follow-up, three Tertiary Care

Centers, and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention Services (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives, Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

CYSHCN are referred into NJ's preventive and primary system of care through mandatory and/or informal pathways. Mandatory reporting by medical providers is required for infants/children that rule in for reportable conditions identified via the Newborn Biochemical Screening and the Birth Defects and Autism Registry Services programs, and in NJ reporting is linked to access to care. The expansion of newborn biochemical screenings to 54 reportable disorders reinforces the continued need to maintain an in-state body of providers to treat children with these conditions, as well as a potential increase in number of referrals to the SPSP agencies, subsequent reporting to the BDARS, follow-up by SCHS CM and the provision of family support. Receipt of referral by the BDARS results in outreach by the SCHS CMUs, whereby families are offered follow-up and linkage to services. Follow-up is recorded in the electronic Case Management Referral System (CMRS), which provides a system for Title V to review and analyze follow-up. Likewise, the SCHS CMUs and SPSP agencies submit registrations of CYSHCN with reportable conditions to the BDARS. Additional formal referral mechanisms that result in linkage to the SCHS CMUs includes the State Data Exchange of SSI applicants under age 16 years and CICRF applicants. Informal linkages to SCHS CM and/or SPSP include self-referral by families, and referral by community-based family support and providers for pediatric specialty/subspecialty outpatient care.

Through Title V support, each of NJ's 21 counties maintains an SCHS CMU partially funded by its Board of Chosen Freeholders to promote access to preventive and primary care for CYSHCN. With parental consent, SCHS CMUs work with the child's parents, physician and/or specialists to evaluate an affected child's strengths and needs; and collaborates with the family and community-based partners to develop an individual service plan (ISP) for the child and family. Medical, educational, developmental, social, emotional and economic needs of the child and family are targeted. Statewide SFY 2014 data indicate that 11,241 CYSHCN were served, 7,550 ISPs developed, 4,775 SSI referrals received and 3,100 CYSHCN were on SSI. The age distribution indicates that the majority of CYSHCN served are age 5-13 years (45%), age 1-4 years (22%), birth to 364 days (18%), age 14-19 years (13%), and those over age 20 (3%). Nearly 98% served are documented to have insurance, of which 61% are enrolled in a Medicaid managed care organization. Nearly 25% self-identify as Hispanic, and race data indicates 49% white, 16% black, 4% Asian, 6% more than one race, 4% other, and 21% unknown. Quality assurance is underway to reduce the number reported as unknown. All SCHS CMUs are required to assess the health care needs and insurance status of CYSHCN served.

State Title V staffs, SCHS CMUs and SPSP providers, and SPAN Family Resource Specialists receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports, how to care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSHCN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with Autism and significant developmental delays by advocating on Mom's behalf with PerformCare, her child's school district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

Recognizing that SCHS CM and family support are valuable in assisting families of CYSHCN to access care, Title V works collaboratively with the SCHS CMUs and family support organizations, including Family WRAP (Wisdom, Resources, and Parent to Parent.) Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey. SPAN and SCHEIS have continued to identify/develop resources to expand the number of Family Resources Specialists (FRS) trained as support specialists to work on site at the SCHS CMUs or regionally. In SFY 2014, Family WRAP projects

including the supplemental Superstorm Sandy family support provided over 38,000 parent/professional contacts. Through supplemental funding provided by the federal Parent Training Information Center (PTI) and Superstorm Sandy Block Grant, additional FRSs have been added for statewide support. In addition, Title V, Early Intervention Services, SPAN, and other community-based partners are collaborating on an AMCHP sponsored "Learn the Signs. Act Early." initiative. Ms. Deepa Srinivasavaradan, SPAN FRS and Act Early Ambassador is leading parent-led screening trainings for early childhood programs and FQHCs; likewise, she will lead NJ's team at the Northeast Regional Act Early conference in May 2015.

Through collaboration with SPAN, the NJ Academy of Pediatrics' Pediatric Council on Education and Research (NJ AAP), SCHS CMUs, SPSP providers, and the Community of Care Consortium efforts are ongoing to improve access to coordinated preventive and primary care through medical home. NJ Title V supports a project with NJ AAP to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State. The SPSP, SCHS CMU, and Family WRAP projects will continue to collaborate and provide technical assistance to providers participating in this initiative.

Preventive and primary care services are in demand and most recent data indicate that an 11% increase in CYSHCN served was noted across SPSP services; 54,492 (SFY 2013) vs. 60,530 (SFY 2014). Comprehensive multidisciplinary team evaluation is provided through the CECs to assess the needs of children with congenital or acquired neurodevelopmental disorders including communication, learning, and behavioral disorders. A copy of the team-based plan of care is provided to the family of the CYSHCN and/or their primary care physician of record. In 2014, 29,273 CYSHCN were seen at the CECs for multidisciplinary evaluations including FAS, and the most frequently diagnosed conditions include Attention Deficit Hyperactivity Disorder (ADHD), Behavior Disorders (15%), Psychiatric (11%), Speech Disorders (10%), and Autism (10%). The majority of CYSHCN evaluated (59%) are between 5 and 13 years of age. Furthermore, more than 89,143 visits were reported. Of note, 47% CYSHCN served were enrolled in one of the Medicaid programs, <1% were uninsured, and 59% were aged 5-13 years. Race data indicated 54% white, 15% black or African American, 4% Asian, 2% more than one race and 25% unknown/unreported. Nearly 23% reported Hispanic ethnicity. Quality assurance is underway to reduce reporting "unknown" race.

Access to in-state pediatric specialty and subspecialty care is further provided through NJ's Cleft Lip/Palate Craniofacial Anomalies Centers and Tertiary Care Centers. Multidisciplinary teams ensure that patients receive necessary medical, nutritional, and developmental care, and that there is coordination of care with primary care providers, sub-specialists, hospitalists, and other community-based providers such as FQHCs. A total of 31,093 CYSHCN received evaluations and services through the five Craniofacial Centers and three Tertiary Centers in 2014. SFY 2014, data indicate that 1,933 CYSHCN were served through the Cleft Centers, of which 54% were insured through State Medicaid program; 32% had some form of private insurance, and 12% of children's insurance status was reported as uninsured/unknown. Quality assurance is underway to reduce reporting of "unknown" insurance status. Nearly 38% were age 5-13 years, reinforcing the need for continuation of coordinated care through school age. Race is represented as follows: 70% white, 1% Black or African American, 10% Asian, and 11% unknown. Coordination with community-based dental providers including orthodontia remains a challenge, and collaboration with patients' care management organizations is helpful to resolve access. The Tertiary Centers reported over 29,000 clients served in SFY 2014, with the majority (38%) reported as age 5-13 years. Again these Centers of Excellence as noted in the NJ Medicaid Managed Care Contract fill a need for specialty care providers that accept Medicaid with nearly 58% served reported being enrolled in a NJ Medicaid/NJ FamilyCare program, and only 1% were uninsured, and 1% paying for care on a sliding scale. Specialty services in greatest demand during that same time period include; Cardiology (15%), Endocrinology (12%), Neurology (10%), Oncology (9%), and Dermatology and Radiology respectively at (8%).

This complement of Centers fills a critical in-State need for access to pediatric specialty and subspecialty care, and the providers are vested in providing family centered care. A family satisfaction survey was

launched in 2014, to gather family input on their experiences with services and access to care. Although data is under review, preliminary findings are described in State Overview.

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed through access to foreign language interpreters and/or interpreters for the deaf. Of note, the SFY 14 family satisfaction survey administered to families of children who received services through an SPSP provider indicated a significant number of English as second language respondents. Of the 1,800 surveys administered, 19% were completed in Spanish. This small but significant finding reinforces the value of language and cultural support. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked with the SCHS CMU located in their county of residence.

Aligned in the FCCS program but funded through Ryan White Part D (RWPDP), the Family Centered HIV Care Network served 2,400 clients in SFY 2014. It continues to provide expert medical case management and access to preventive and specialty care services for women, infants, children and youth (WICY) across State, federal and local systems. These regionalized providers also serve a key role in developing and presenting educational offerings in collaboration with the AIDS Education Training Center. These multidisciplinary and consumer targeted programs include topics such as perinatal care for the infected woman, care of the exposed infant, retention in care, and transition to adulthood are offered to State staffs in Title V programs as well as community-based SPSP, SCHS CM, and family support provider agencies. Of note, the number of HIV-infected newborns and children has steadily decreased in the past four years, while the number of HIV-infected adolescents has steadily increased over the same time period. Consequently, the RWPDP and Title V services share common goals in ensuring adequate insurance, access to medical home and specialty care, and transition to adulthood services as needs for its adolescent populations. Educational opportunities and tools to meet specialty care needs are shared among these systems.

Through the Fee-For Service (FFS) program State Title V staffs and county-based Special Child Health Services Case Managers (SCHS CM's) process requests for assistance with uncovered expenses for medically necessary services such as hearing aids, braces, orthotics, prostheses, and medications to treat asthma and cystic fibrosis. In SFY 2014, 50 CYSHCN received benefits through FFS. 100% of FFS applications are screened for NJ Medicaid, NJ FamilyCare, and/or accurate interpretation of their commercial health coverage and are referred to their county SCHS CMU for supports. The demand for assistance to purchase hearing aids for youth age 18-21 has gradually increased. NJ's Grace's Law and the Affordable Care Act (ACA) have improved coverage, an example being that hearing aid coverage is now considered an essential health benefit. However some families continue to experience gaps in coverage and require assistance through FFS, for example, those with grandfathered plans, certain employer-sponsored plans, and those ineligible for State programs due to residency have found that some challenges remain. Likewise, challenges continue for CYSCHN, families, and providers, in understanding insurance benefits and how to use them, particularly for families with limited English proficiency. Title V staffs, the SCHS CMUs, and SPAN Family Resource Specialists are instrumental in assisting CYSCHN to understand and use their coverage. For example, with the implementation of Grace's Law in 2008, certain health benefit plans were mandated to provide limited coverage of \$1,000 per hearing aid for children 15 years and younger every 24 months. Subsequently, the ACA prohibited annual or lifetime benefit limits on essential health benefits. Consequently, the inclusion of hearing aids as an essential health benefit is a strength for families of CYSHCN; however, the NJ specific \$1,000 benefit limit no longer applies. This change presents the potential for an increase in out-of-pocket expenses for some CYSHCN, and challenges for hearing aid dispensers to renegotiate reimbursement with insurance carriers. To that end, State Title V staffs, the State Audiologist, and SCHS CM's provide

technical assistance to applicants, providers, insurance providers, and Human Resource departments as needed.

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification, outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth to 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the CICRF; by community, family and self-referrals; and through the Department of Human Services transmittal of Social Security Administration's Supplemental Security Income (SSI) data provided via the State Data Exchange.

The SSI transmittal is electronic and enables the NJDOH to conduct monthly uploads of county-specific reports which are then viewable by the SCHS CMUs through the NJDOH's secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSI to offer information and referral; development of an ISP; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. With electronic access to their county-specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. State FCCS staffs monitor the transmittal and follow-up of SSI referrals by the SCHS CMUs, and status of follow-up has been included as an indicator on the SCHS CMU evaluation tool.

## **B.2b. iii MCH Workforce Development and Capacity**

This section describes the strengths and needs of the state MCH and CSHCN workforce, including the number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs. Included in the summary formatted as a table are the names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities. Also included in the summary are the number of parent and family members, including CSHCN and their families, who are on the state Title V program staff and their roles (e.g., paid consultant or volunteer.) In addition, MCH workforce information such as the tenure of the state MCH workforce is included in the summary.

Maternal and Child Health Services (MCHS) is comprised of three program managers, 16 professionals, and 6 support staff. All staff members are housed in the central office. The Service Director for MCHS position recently became vacated in April 2015 when the previous Service Director, Lorraine Freed Garg, MD, MPH a pediatrician with a subspecialty in Adolescent Medicine, moved out of state.

Reproductive and Perinatal Health Services (RPHS) is staffed by 10 professionals and 3 support personnel and a Program Manager. The Program Manager position is currently vacant. The program is responsible for the regional MCH Consortia, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Title V Liaison with the Healthy Start projects, Family Planning, perinatal addictions and fetal alcohol syndrome prevention projects, postpartum mood disorders initiative, Improving Pregnancy Outcomes Initiative, and preconceptional health. Several professional staff members participate in the various subcommittees of the Home Visiting Work Group. The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Improving Pregnancy Outcomes Initiative. Resources for staff have been from federal MCH Block Grant, MIECHV, and the Preventive Health and Health Services Block Grant.

The Child and Adolescent Health Program (CAHP) is comprised of 5.5 professional staff - 3 in Child Health, 2.5 in Adolescent Health, 1 paraprofessional MIS Technician, 1 administrative support staff and the Program Manager. Funding resources include both federal (MCH Block Grant, CDC cooperative agreement for Lead, DHHS, FYSB, ACF Title V Abstinence Education Program [AEP] and DHHS, FYSB, ACF Personal Responsibility Education Program [PREP]) and state (MCH and Lead childhood lead

poisoning). All staff are housed in the Trenton office. The CAHP Manager has oversight responsibilities for childhood lead poisoning and prevention and teen pregnancy prevention and CDCs Coordinated School Health/WSCC model in public schools, grades six and above. Childhood Lead Poisoning and Prevention has one Primary and Preventive Health Services Coordinator, 2 professionals and 1 paraprofessional. Child Health was awarded Sandy Recovery funding in the amount of \$13.2M for 3 components: 1) Public education and professional development; 2) blood lead screening/testing using the LeadCare II analyzer; 3) limited intervention case management services.

Teen pregnancy prevention staff consists of one full-time PREP Coordinator and one part-time AEP Coordinator that was hired March 2014. An AEP Coordinator position was approved to hire on March 28, 2015. One professional staff person is assigned responsibility for the CDC CSH/WSCC project and the position is currently vacant. CAHP staff have varied professional backgrounds including nursing, nutrition, health education, research and data analysis.

Child Health was awarded Superstorm Sandy Recovery funding in the amount of \$10.3M for 3 components: 1) Public education and professional development; 2) blood lead screening using the LeadCare II analyzer, limited nursing interventions, and dust and soil sampling of targeted housing; 3) enhancement of HomeTrax (a healthy homes database).

Community Health and Wellness Services in the Division of FHS was awarded the CDC 1305 cooperative agreement: State Public Actions to Prevent Chronic Disease ...and Promote School Health, for basic and enhanced components.

The Children's Oral Health Program (COHP) is comprised of 1 professional staff who reports to the Director of Maternal Child Health Services. Dr. Beverly Kupiec-Sce directs program activities which are implemented through regional based programs strategically located in the north, central and southern regions of the State. As COHP Director, Dr. Sce maintains a gubernatorial appointment to the NJ State Board of Dentistry and was one of 19 doctoral prepared nurses nationwide appointed to the National Nursing Workgroup on Oral Health which is a component of the National Interprofessional Initiative on Oral Health. The role of the National Oral Health Nursing Workgroup is to shape nursing's role in advancing a national oral health agenda and serves as an expert advisory committee providing input related to nursing's role in improving oral systemic health outcomes as well as expanding access to and reducing disparities in oral health.

The [Maternal and Child Health Epidemiology Program \(MCH Epi\)](#) provides MCH surveillance and evaluation support to MCHS. The mission of the [MCH Epi](#) Program is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professional positions. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#) survey is coordinated by the MCH Epi Program. Ingrid Morton is the Program Manager for MCH Epi. Two research professional positions are currently vacant.

### **Special Child Health and Early Intervention Services (SCHEIS)**

Special Child Health and Early Intervention Services (SCHEIS) consist of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and the Early Intervention System.

Dr. Marilyn Gorney-Daley is the Director of SCHEIS. Dr. Gorney-Daley is board certified in General Preventive Medicine and Public Health; she has worked in NJDOH since 1995 and had served as Medical Director for SCHEIS previously. All SCHEIS staff members are housed in the central office.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects, special needs, and pulse oximetry, Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of 8 professionals, 6 support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and 2 CDC cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 11 professionals and 3 support staff.

The Family Centered Care Services Program (FCCS) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded Case Management Units, Family WRAP family support services, 10 Child Evaluation Centers which include 6 FAS Diagnostic Centers, 5 Cleft Lip/Cleft Palate centers, 3 Tertiary Care Centers, 2 Organ Donor and Tissue Sharing Donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of 7 professionals, 2 support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Nancy Mimm, RN, MSN, Ms. JoAnn Ayres, RN, M.Ed. coordinates SPSP, and Mrs. Ellen Dufficy, RN, M.Ed. coordinates Ryan White Part D.

The FCCS program welcomed 3 new staffs; Ms. Linda Barron, RN, MSN project officer for Case Management services, Ms. Stephanie Kneeshaw-Price, Ph.D. health data specialist Case Management and Ms. Neha Chopra, MPH, health data specialist support to the SPSP and RWPDP programs. However, 2 staff vacancies remain; one public health nurse and one clerical. Strategies to fill the vacant professional position is underway, including special services and seasonal contract staff.

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

To promote and provide culturally competent approaches in its services delivery across programs, NJ actively:

- (1) Collects and analyzes data according to different cultural groups (e.g. race, ethnicity, language) and use the data to inform program development and service delivery.
- (2) Ensures the provision of training for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence.
- (3) Collaborates with informal community leaders/groups (e.g. natural networks, informal leaders, spiritual leaders, ethnic media and family advocacy groups) and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/ monitoring/quality improvement activities.
- (4) Secure allocation of resources to adequately meet the unique access, informational and service needs of culturally diverse groups.

- (5) Develop and implement performance standards for staff and contractors that incorporate cultural competence practices and policies.  
(6) Provide policies and guidelines that support the above identified items and approaches.

Staffing for MCHS

Staff Person	Title	Function	Related NPM	Tenure in MCH
Gloria Rodriguez	Assistant Commissioner	MCH Title V Director	1-15	
Nashon Hornsby			1-15	
vacant	MCHS Director	Director of MCHS Services Unit	1-15	
Lakota Kruse	Medical Director	HV Program Director	1-15	22
vacant	RPHS Program Manager	Oversees RPHS	1-15	
Cynthia Collins	CAHS Program Manager	Oversees CAHS	7-12	22
Maggie Gray	Coordinator Primary & Preventive Health Services	Coordinator RPHS programs	1-6	18
Anna Preiss	Research Scientist 2	Coordinator MIECHV and RPHS programs	1-6	20
Renee Booze-Westcott	Program Specialist 3	Coordinator RPHS programs	1-6	22
Elizabeth Dahms	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	15
Jasmine Osol	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	5
Loletha Johnson	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	15
Gilo Thomas	Public Health Consultant 1 Nursing	PREP Coordinator	7-12	10
Crystal Owensby	Coordinator Primary & Preventive Health Services	Coordinator Lead program	7-12	22
Jaydeep Nanavaty	Research Scientist 1	Data and TA for Lead Program	7-12	15
Pat Hyland	Public Health Consultant 1 Nursing	Coordinator RPHS programs	7-12	22
Beverly Kupiec-Sce	COHP Director	Directs COPH activities	13	29
Ingrid Morton	MCH Epi Program Manager	Manages MCH Epi programs	1-15	22
Sharon Smith	Research Scientist 2	PRAMS Coordinator	1-15	12

Staffing for SCHEIS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Marilyn Gorney-Daley	Director SCHEIS	Service Unit Director, Director for CSHCN	13, 14	18 yrs
Diane DiGiovacchino	Administrative Assistant 3	Administrative support	13,14	27 yrs
Rita Belfiore	Secretarial Assistant 3	Secretarial support	13,14	27 yrs
Leslie Beres-Sochka	Program Manager, Early Identification & Monitoring	Supervises activities of Early Identification and Monitoring Program (EIM)	13, 14	22 yrs
Joseph Sweatlock	Research Scientist I	Responsible for data management for EIM	13, 14	11 yrs
Kathryn Aveni	Research Scientist I	Supervises activities of Early Hearing and Detection	13, 14	13 yrs

		<i>Intervention</i>		
<i>Mary Knapp</i>	<i>Coordinator Primary and Preventive Health Services</i>	<i>Coordinator NJ Birth Defects Registry</i>	<i>13, 14</i>	<i>30 yrs</i>
<i>Linda Biando</i>	<i>Public Health Consultant 1, Nsg</i>	<i>Provides follow up with medical professionals</i>	<i>13, 14</i>	<i>25 yrs.</i>
<i>Nicole Moore</i>	<i>Principal Clerk Typist</i>	<i>Provides clerical support for Birth Defects and Autism Registry</i>	<i>13, 14</i>	<i>15 yrs</i>
<i>Donna Williams</i>	<i>Head Clerk</i>	<i>Provides supervision of clerical staff for Birth Defects and Autism Reg.</i>	<i>13, 14</i>	<i>10 yrs</i>
<i>Tracy Justice</i>	<i>Principal Clerk Typist</i>	<i>Provides clerical support for Early Hearing Detection &amp; Intervention</i>	<i>13, 14</i>	<i>12 yrs</i>
<i>Mary Lou Colon</i>	<i>Secretarial Assistant 3</i>	<i>Provides clerical support for Program Manager of EIM</i>	<i>13, 14</i>	<i>7 yrs</i>
<i>Raymia Geddes</i>	<i>Principal Clerk Typist</i>	<i>Provides clerical support for Birth defects and Autism Registry</i>	<i>13, 14</i>	<i>3 yrs</i>
<i>Pauline Lisciotto</i>	<i>Program Manager</i>	<i>Administer FCCS Unit; SCHS Case Management &amp; Family Support, Fee for Service, Specialized Pediatric Services program (SPSP), Ryan White Part D activities</i>	<i>13, 14</i>	<i>22 yrs</i>
<i>Jo-Ann Ayres</i>	<i>Public Health Nurse Consultant 1, Specialized Pediatric Services Program (SPSP)</i>	<i>Public health nurse consultation re: SPSP programs and services, program officer for SPSP health services grants</i>	<i>13, 14</i>	<i>15yrs</i>
<i>Neha Chopra</i>	<i>Health Data Specialist 3</i>	<i>Support SPSP program's data collection and analysis, administer family satisfaction survey</i>	<i>13, 14</i>	<i>1 yr</i>
<i>Nancy Mimm</i>	<i>Public Health Nurse Consultant 1, Special Child Health Services Case Management (SCHS CM)</i>	<i>Public health nurse consultation re: SCHS CM programs and services, program officer for SCHS CM health services grants</i>	<i>13, 14</i>	<i>1 yr</i>
<i>Felicia Walton</i>	<i>Program Specialist 3</i>	<i>Public health consultation re: SCHS CM programs, family support, and Fee for Service program, program officer for SCHS CM health services grants</i>	<i>13, 14</i>	<i>5 yrs</i>
<i>Linda Barron</i>	<i>Public Health Nurse Consultant 2, Special Child Health Services Case Management (SCHS CM)</i>	<i>Public health consultation re: SCHS CM programs, family support, and Fee for Service program,, program officer for SCHS CM health services grants</i>	<i>13, 14</i>	<i>10 mos.</i>
<i>Stephanie Kneeshaw-Price</i>	<i>Health Data Specialist 1</i>	<i>Lead SCHS CM and Superstorm Sandy data collection and analysis, administers SCHS CM electronic case management referral system</i>	<i>13, 14</i>	<i>6 mos</i>
<i>Susan Agugliaro</i>	<i>Secretarial Assistant 3</i>	<i>Clerical support to Program Manager and maintains Fee for Service Letters of Agreement</i>	<i>13, 14</i>	<i>28 yrs</i>

<i>Kenette Johnson</i>	<i>Principal Clerk Typist</i>	<i>Clerical support to SCHS CM and SPSP programs</i>	<i>13, 14</i>	<i>10 yrs</i>
<i>Parents/Family members</i>				
<i>Statewide Parent Advocacy Network Diana Autin (grantee)</i>	<i>Executive Director</i>	<i>Parent Partner</i>	<i>13, 14</i>	<i>20+</i>

Title V SCHEIS staff are active participants and represent the NJDOH on the New Jersey Statewide Network on Cultural Competence (NJSNCC) to ensure that there is access to equitable and quality services for individuals, families, and communities through culturally and linguistically appropriate service delivery. As part of their mission, the NJSNCC holds an annual conference for service providers, policymakers, researchers and other stakeholders on culturally competent care. At the most recent annual conference, on September 12, 2014, two presentations focused on the delivery of culturally competent care in a medical home. The first entitled “Improving Medical Homes For Immigrant Children with Special Healthcare Needs Served by FQHC’s: A New Model of Care and Parent Empowerment” took the perspective of a parent with a child with special health care needs and the importance of navigating services in an environment that is supportive and engaging.

Highlights from this presentation included:

- Improving access to medical homes for immigrant CYSHCN and their families in targeted high-need, high-immigrant/LEP communities, by enhancing the capacity of FQHCs in those communities.
- Improving the ability of immigrant, underserved families of CYSHCN, including behavioral health needs, in high-need, high-poverty communities.
- Enhancing care coordination for immigrant families of CYSHCN in targeted high-needs, high-poverty communities by addressing interrelated medical, social, developmental, behavioral, educational and financial needs of families to achieve optimal health and wellness outcomes.

A second presentation was also given at the NJSNCC annual conference on medical homes entitled “Becoming a Culturally Competent Medical Home: A Model for Providing Patient and Family-Centered Care to Children with Seizure Disorders.” Highlights of this presentation included the following:

- Creating a model for getting the best health care and the best coordination of care, by providing ongoing and sustainable methods of communication with the individual’s health care providers.
- Having “cultural brokers” who can be other parents in the community, a minister, or a faith-based organization, that can help the family in identifying resources that are culturally appropriate to their needs.
- Engaging the community and creating partnerships in addressing specific gaps in quality of care.
- Educating the primary and other health care providers about the diverse cultural needs of families of children and youth with special health care needs.
- Developing a good Comprehensive Health Care Plan that can be implemented with more meaningful and successful results.

The NJSNCC recently began conducting webinar presentations for services providers and other interested individuals that focus on cultural competence. During the 2015 Spring Webinar Series, presentations on medical homes were continued, but a more global perspective was taken which included all children and youth with special health care needs (CYSHCN). The presentation focused on how a culturally competent medical home can have more impact and positive results in caring for CYSHCN and their families. The presentation aimed to:

- Define and identify methods for building a culturally competent medical home.
- Review strategies to connect CYSHCN with a culturally competent medical home provider.
- Discuss approaches that can be used to engage the practice team and integrate care navigators within clinical practice settings.

- Describe incentives to engage the medical providers to buy into the medical home concept.
- Customize a medical home model that fits your community needs and effective methods to educate families about the medical home.

Additional webinar presentations on medical homes are being planned for the Fall of 2015.

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with the DOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support MCH Epidemiology Program and SCHEIS Program. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions were related to retirements, resignations and promotions.

DOH recently planned a Performance Management Training. Two classroom training sessions were held in June, in addition to a webinar that was available to all staff. This training will provide staff to oversee and improve the actions that it takes to enact health policies and plans, to assess health outcomes of at risk maternal and child health communities and to adapt or change policies in order to better achieve the desired outcomes. The establishment and implementation of a Performance Management System is also a sound operation and management practice and a requirement for successful Public Health Accreditation as the Department seeks to become a nationally accredited health department.

### **II.B.2.c. Partnerships, Collaboration, and Coordination**

This section summarizes the relevant organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CSHCN programs. The following table summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

*MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination*

<i>Domain</i>	<i>State Priority Needs</i>	<i>MCHB Investment Grant</i>	<i>Other Investments</i>	<i>Other DOH</i>	<i>Other State Departments</i>	<i>Local Agencies</i>	<i>Performance Measures/Goals</i>	<i>Family Consumer Partnerships</i>
1) Maternal/ Women's Health	#1 Increasing Healthy Births,	MIECHV,	FQHC, Family Planning	HIV/AIDS; WIC; CH&W	DCF, DHS, DOE	IPO grantees, MCHC, MIECHV grantees	IPO objectives; HV Benchmarks; NPM 1,2,3; NOM 1-8,21,22	HV Advisory WG
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality,	MIECHV, Healthy Start, SSDI	FQHC, WIC; SUID-CR	NJIIS; WIC	DCF, DHS, DOE	IPO grantees, MCHC, MIECHV grantees	IPO objectives; HV Benchmarks; NPM 5; NOM 1-9	HV Advisory WG
3) Child Health	#2 Improving Nutrition & Physical Activity		FQHC, CSH/WSCC ;SDYR	CH&W	DCF, DHS, DOE, DEP, JJC, DoT	WSCC grantees	WSCC objectives; NPM 8; NOM 9,11	CSH/WSCC Partners
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	PREP, AEP	FQHC, CSH/WSCC ;SDYR	HIV/AIDS; CH&W	DCF, DHS, DOE	PREP & AEP grantees	WSCC objectives; PREP & AEP objectives; NPM 11,12 NOM 10,11,13,15-17	CSH/WSCC Partners
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	CSHCN SIG	SCHS CMUs, SPSP grantees	EIS,WIC, FQHC, Div of HIV/AIDS,S TI,TB;Div of PHILEP	DCF, DHS, DOE, DOBI, CICRF, NJ Council on DD	Local health depts., hospitals, special services school districts, disability specific/charitable agencies	NPM 11,12; NOM 18,19,20,23	SPAN/Family WRAP, COCC
6) Life Course	#7 Improving & Integrating Information Systems #8 Smoking Prevention	SSDI		CH&W	DCF, DHS, DOE		NPM 13,14	

This section describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

This section also describes the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the [Maternal Child Health Consortia \(MCHC\)](#), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state, with the northern region representing the largest number of births.

School health coordination and collaboration is accomplished statewide through funding to three regional CSH grantee agencies, each with a seven-county service area. Through a mini-grant opportunity developed in SFY2014 and implemented in SFY2015, the CSH regional grantees and Adolescent Health State staff worked with various advisory “experts” from state government or professional statewide organizations to develop (SFY 2014) and implement (SFY2015) a mini-grant application in each of the Coordinated School Health model components. State Departments represented included: Agriculture, Children and Families, Education, and Environmental Education. The USDA Mid-Atlantic Regional Office and Rutgers University also participated. Professional statewide organizations were represented by: NJ Association of Health, Physical Education, Recreation and Dance, NJ Society for Public Health Education (SOPHE), NJ State School Nurses Association, and Campaign Connect (Center for Supportive Schools). To address school health and adolescent risk-taking behavior, DOE formalized a partnership with DHSS, through the use of a MOA, for implementation of CDC's Coordinated School Health (CSH) model. In addition to DOE and DHSS, there is state department representation from: Agriculture (NJDA); Children and Families (DCF) School Based Youth Services Program, Environmental Protection (DEP), the Juvenile Justice Commission (JJC) and Transportation's (DOT) Safe Routes to School.

Coordination between the State's Primary Care Office and FQHCs continues. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office. The Office of Primary Care has provided cost-base reimbursement to qualified FQHCs for eligible visits by uninsured and underinsured individuals since 1991. Funds to compensate the centers for uninsured visits are derived from the Health Care Subsidy Fund, which is financed by an assessment on hospital operating revenues.

The Federally Qualified Health Centers (FQHCs) operate in all of NJ's 21 counties. The 20 FQHCs have a combined 110 licensed satellite sites throughout the State. As a consequence of expansion and capacity-building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2014, almost 212,000 uninsured residents were serviced and over 522,000 uninsured visits reimbursed. The portion of the annual assessment that is allocated to the FQHCs in SFY 2015 is \$31 million. In SFY 2015, the FQHC–Uncompensated Care Fund is funded at \$31 million.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), located in the NJDOH, partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals,

advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Title V CYSHCN program works with programs within DHS and DCF in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

On July 1, 2014, the DHS implemented its Managed Long Term Services and Supports (MLTSS) Waiver, which was a major reconfiguration of NJ's Medicaid services with the intent to eliminate the silo effects of separate programs and waivers. The goal of MLTSS is to provide quality long-term services and supports to individuals of all ages in the least restrictive setting appropriate to meet their needs. NJ Title V CYSHCN had provided consultation and technical assistance to DHS, Office of Medicaid Managed Care through participation on multiple planning committees regarding the complex needs of CYSHCN and their families in the community. At present, Title V continues to work with DHS Office of Medicaid Managed Care and contribute expertise in the area of CYSHCN as well as facilitate trainings for county case management units regarding MLTSS.

In the comprehensive context of the significant reorganization of waiver services, changes afforded through the Affordable Care Act including the expansion of eligibility of NJ Medicaid, as well as access to services through the DHS's Division of Developmental Disabilities and the DCF, represent major systems changes for families of CYSHCN and the providers that serve them. The quarterly Special Child Health Services Case Management Unit meetings provide training opportunities for community-based providers, staff, Specialized Pediatric Services Provider agencies, Early Intervention System staff, and families of CYSHCN to be educated on systems changes, discuss their impact and provide opportunities for dialogue and problem solving.

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waived services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected put in to a report which is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

SCHEIS also maintains a memorandum of agreement with DHS Medicaid to facilitate operation of the SCHEIS Fee-for-Service program, which ensures access to medications for the treatment of children with asthma and cystic fibrosis through NJ Medicaid participating pharmacies. Likewise, DHS staff that administer Medicaid durable medical equipment services and SCHEIS Fee-for-Service collaborate on technology and resource trends related to hearing aids, braces, and orthotics.

The DHS, Division for the Deaf and Hard of Hearing (DDHH), partners in planning access to care and service delivery for CYSHCN with impaired hearing. SCHEIS staff and DDHH staff cross refer CYSHCN and their families for services and supports. Advocacy, employment and vocational opportunities, sign language interpreter services and assistance with social, legal, medical, educational, and recreational issues are examples of services that SCHS CM and the Specialized Pediatric Services providers refer CYSHCN to DDHH.

Collaboration between SCHEIS staff, SCHS CM and/or Specialized Pediatric Services providers and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management

services, and administrative support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of NJ (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits.

The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSHCN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CM and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to adulthood supports.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source. By legislative mandate, SCHEIS participates on the CICRF Commission. SCHEIS maintains a memorandum of agreement (MOA) with the CICRF program to formally refer children birth to 21 years of age whose families have accumulated medical debt for the care and treatment of their children's medical condition. All applications received by the State CICRF program are forwarded to the SCHS CMU in the CYSHCN's county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS.

The [NJ Council on Developmental Disabilities \(NJ CDD\)](#) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in NJ State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD. The purpose of the NJ CDD is to engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42:CFR446.10 of the Social Security Act. The 15-member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in implementation of MLTSS, and the restructuring of services to children and youth with the developmental disabilities through DDD, DCF, DOE and DOL, Vocational Rehabilitation. The State Title V program continues to attend the MAAC meetings and contribute expertise in the area of CYSHCN as needed.

In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with the Department of Banking and Insurance (DOBI), Division of Insurance colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings. State SCHEIS staffs are dialoguing

with DOBI staff in planning for NJ implementation of the Patient Protection and Affordable Care Act (PPACA).

The DCF is focused on strengthening families and achieving safety, well-being, and permanency for all NJ's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

The Statewide Parent Advocacy Network (SPAN) and the NJ-AAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium, a leadership group of SPAN, dedicated to improving New Jersey's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and AAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The Community of Care Consortium partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care (NAMI) has been developed and shared with families. Community of Care co-conveners continue to meet with New Jersey's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care.

Linkages with the DCF's Division of Prevention and Community Partnerships, Division of Community Services, and Office of Education ensures access to behavioral health providers, emergency response providers, the DCF child health nurses, and local child protection services offices. These linkages are essential for SCHS Case Managers, Specialized Pediatric Services (SPS) provider agencies, Ryan White Part D (RWPD) providers, EIS, and other DHSS programs to maintain capacity to serve the State's most vulnerable children.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation. The Division of Vocational Rehabilitation (DVR) Services is responsible for training and placement of persons of employable age with disabilities. As SCHEIS counsels families on transition to adulthood planning options, programs regularly refer to DVR. Likewise, DVR staffs collaborate with SCHEIS programs on family and provider training, individual service plan, and individualized education plan development.

Childcare is a need for CYSHCN, and SCHEIS collaborates with MAPS to Inclusive Child Care Training and Technical Assistance Project, Healthy Start programs, as well as the MCCH Adolescent Health unit. The goals of the project are to increase the quality of early care and education for children with special needs; increase the number of child care providers that offer inclusive child care; increase awareness among parents, child care providers ,and child care resource and referral agencies of the services available for children with special needs; and improve the delivery of services for children with special needs through collaboration among providers of child care services and special needs services. Its focus remains planning to develop strategies that facilitate and enhance the inclusion of CYSHCN in child care settings.

Linkage with access to primary care is coordinated with NJ's Office of Primary Health and the local Centers for Primary Health Care. These Centers refer CYSCHN to the SCHS Specialized Pediatric Service providers as well as to the SCHS CMUs for assistance in coordination. The Centers serve the uninsured and underinsured, as well as patients with Medicaid, Medicare and private insurance. If uninsured, family's bills are based on their ability to pay. No one is ever turned away for lack of funds.

Title V works with many different partners to help ensure NJ is on the cutting edge with newborn screening policies and operations in NJ. The Newborn Screening Advisory Review Committee (NSARC), established by Executive Order from the Commissioner includes parents, primary care physicians, specialists, nurses, health care organization representatives, including those from Medicaid and private health plans, advocacy organizations, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention, an ethicist, and several others. NSARC meets twice a year in person and as needed via webinar, phone, or additional in-person meetings.

NJ's Title V Program works with many federal partners and other state/territory colleagues to share and gain information on services and initiatives for CYSHCN. In March and May of 2015, NJ's Title V Program participated in technical assistance calls arranged through HRSA's MCHB to share information on NJ's critical congenital heart defects screening program and the autism registry respectively. In May 2012, NJ was one of six states to receive a 3-year HRSA-funded implementation grant for pulse oximetry screening to detect critical congenital heart disease (CCHD). NJ was the first state in the nation to implement mandatory screening, and a number of infants have been detected through this screening that might otherwise have been discharged from the hospital without detection. Implementation of screening has been a collaborative effort with representation from the American Academy of Pediatrics (AAP), NJ Chapter and SPAN on the NJDOH CCHD Screening Working Group. In addition, the grant has enabled us to expand our educational and training efforts throughout the state with a subgrant to the AAP, NJ Chapter. This grant received an extension and is expected to conclude in February 2016.

## II.C. State Selected Priorities

*In this section, states shall list the seven to ten highest priority needs they identified based on the findings of the Five-Year State Priority Needs selected by New Jersey for its Title V program during the five-year reporting period have been determined by a thorough examination of the findings from the state's Five-Year Needs Assessment, as highlighted in the Needs Assessment Summary of the first-year Application/Annual Report. This section describes the relationship of the State Priority Needs, the National and State Performance Measures, and the capacity and resources of the State Title V program.*

Table X State Priority Needs from Five-Year Needs Assessment Form 9

State Priority Needs (SPNs)	New (N), Replaced (R) or Continued (C) Priority Need for this 5-Year Reporting Period			Rationale including National and State Performance and National Outcome Measure
	N	R	C	
1) Increasing Healthy Births			X	NPM 1,2,3; NOMs 1,2,3,5,6,7,8,21,22; SPM 1
2) Improving Nutrition & Physical Activity			X	NPM 8; NOM 9,11,13
3) Reducing Black Infant Mortality			X	NPM 1,2,3,4,5; SPM 1; NOM 1-9
4) Promoting Youth Development			X	NPM 11,12; NOM 10,11,13,15,16,17
5) Improving Access to Quality Care for CYSHCN			X	NPM 11,12; SPM 3,4,5; NOM 18,19,20,23
6) Reducing Teen Pregnancy			X	NPM 11
7) Improving & Integrating Information Systems			X	All NPMs, SPMs, NOMs
8) Smoking Prevention	X			NPM 14

The State Priority Needs selected by New Jersey for its Title V program during the five-year reporting period have been determined by a thorough examination of the findings from the state's Five-Year Needs Assessment, as highlighted in the Needs Assessment Summary of the first-year Application/Annual Report. This section describes the relationship of the State Priority Needs, the National and State Performance Measures, and the capacity and resources of the State Title V program.

### SPN #1. Increasing Healthy Births

Increasing Healthy Births is a State Priority Need (SPN) that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care adequate prenatal care, and Women's Health. SPN #1 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2 and 3. Several initiatives address healthy births including Healthy Start outreach activities, Community Action Team projects based on FIMR findings, and most recently the Improving Pregnancy Outcome Initiative. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period.

Demonstrating its prioritization of Increasing Health Births, RPHS released in 2014 a competitive request for applications to improve perinatal outcomes, called the Improving Pregnancy Outcomes (IPO) Initiative that requires incorporation of the Life Course Theory and uses the services models of Community Health Workers and Central Intake. Benchmarks in the RFA closely resemble those in the Maternal Infant and Early Childhood Home Visitation (MIECHV) Program. The IPO Initiative replaces the Access to Prenatal Care Initiative. The IPO Initiative is coordinated with existing federal and state-funded initiatives including but not limited to Healthy Start, MIECHV, Strong Start, Title X Family Planning, Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health & Wellness Service Unit of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

## **SPN #2. Improving Nutrition and Physical Activity**

Improving Nutrition and Physical Activity is a State Priority Need (SPN) to address the obesity epidemic. The SPN #2 addresses needs in the population domains of Maternal/Women's Health, Perinatal/Infant Health, Child Health, and Adolescent/Young Adult Health and impacts on NPM #8 and NOMs 9 and 11. NJ had one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.

In May 2008 DHSS was awarded a five-year cooperative agreement by the CDC to the Office of Nutrition and Fitness (ONF) to provide state leadership and coordination of nutrition, physical activity and obesity (NPAO) strategies. Through this cooperative agreement a statewide partnership of more than 320 organizations and individuals, called ShapingNJ, was created to collaborate, build capacity and develop a comprehensive and coordinated system for addressing nutrition, physical activity and obesity (NPAO) prevention strategies in five settings: schools, communities, child care centers, worksites and healthcare facilities. In SFY2014, DOH Adolescent Health staff, in collaboration with Coordinated School Health (CSH) regional grantees and advisory experts from several State departments and state-level professional organizations created three evidence-based or best practice actions each in the physical education and activity and the nutrition services components of the CSH/WSCC model. The physical education actions were developed in collaboration with NJ Association of Health, Physical Education, Recreation and Dance (NJ AHPERD) and the nutrition services actions were developed with guidance from the NJ Department of Agriculture and the USDA Regional Office

The ShapingNJ NPAO CDC cooperative agreement ended in September 2013. The Community Health and Wellness Services was awarded the basic and enhanced components of DP1305. In partnership with the YMCA State Alliance and Partners for Health Foundation, 30 high-risk NJ communities are being funded with small grants of approximately \$10,000 each. These grants will be used to fund the implementation of policy and environmental change strategies to prevent and reduce obesity at the local level. Specifically, each grantee is required to address one food access strategy and one physical activity strategy. Projects include but are not limited to community gardens, healthy corner store initiatives, bike racks, healthy vending machines, complete streets and local farmer's markets.

## **SPN #3. Reducing Black Infant Mortality**

Maternal and Child Health Services (MCHS) has a long history addressing perinatal health disparities with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. SPN #3 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2, 3, 4, and 5. In 1996, the Department established the Blue Ribbon Panel on Black Infant Mortality Reduction. Following release of the report from the panel, an Advisory Panel on Black Infant Mortality was created to implement recommendations from the report including a public awareness campaign and community-based projects to provide outreach and education services in high-need communities.

Following recommendations from the Prenatal Care Task Force, Reproductive and Perinatal Health Services issued a competitive request for applications to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Nine health service grants were awarded for the Access to Prenatal Care Initiative. The grantees targeted the areas that have had the poorest birth outcomes and lowest rates of first trimester prenatal care.

In 2013 NJDOH was invited to participate in the third round of the National Governors Association Learning Network on Improving Birth Outcomes Initiative (NGA IBO Initiative). NJDOH created three working groups to develop key recommendations regarding the improvement of birth outcomes.

In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM ColIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. IM ColIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to improve birth outcomes. The IM ColIN State Team from NJ identified two priority areas - improving postpartum rates and smoking cessation. The NGA IBO Initiative workgroups will continue as the IM ColIN Strategy Teams to develop recommendations for improving birth outcomes and preventing infant mortality.

In 2014 RPHS implemented the IPO Initiative to improve perinatal outcomes to improve prenatal care, preconception care, and interconception care as a means to prevent infant mortality in the highest risk communities. The IPO Initiative through a collaborative coordinated community-driven approach will work to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes. The IPO project CHW and Central Intake will be collaborating with ColIN to implement the recommendations.

#### **SPN #4. Promoting Youth Development**

The SPN #4 Promoting Youth Development addresses the broad needs of the population domain Adolescents and Young Adults. Prior emphasis had been placed on reducing risk-taking behaviors. A more strength-based approach is being emphasized by promoting youth development that will have a positive effect on Life Course and multiple health and wellness outcomes. SPN #4 includes NPMs 7, 8, 10, 11 and 12, and NOMs 9, 11, 15, 16 and 17.

Within MCHS, youth development and teen pregnancy is being addressed by the Personal Responsibility and Education Program (PREP) and ACF's Title V Abstinence Education Program (AEP). Through the Coordinated School Health/ Whole School, Whole Community, Whole Child (CSH/WSCC) project, 22 of 28 (78%) school partners completed a school climate and culture survey and received technical assistance on interpreting the results and potential next step actions to address harassment, bullying and other aggressive or violent behavior. Physical inactivity is addressed by the ShapingNJ Partnership, in the school setting as well as in the community. Again, through the CSH/WSCC Project, 21 of 28 school partners (75%) implemented an individualized fitness assessment (Fitnessgram) to address physical inactivity.

#### **SPN #5. Improving Access to Quality Care for CYSHCN**

NJ will continue to improve access to quality care for CYSHCN through collaboration and partnership building, targeting resources and efforts to maintain capacity and to comprehensively address the six MCHB core outcomes for CYSHCN and State Performance Measures (#3, 4, & 5) in order to achieve its State Priority Need # 5 of Improving Access to Quality Care for CYSHCN.

In an effort to gather information from families concerning needs and improving quality of care, in Spring 2015, a family satisfaction survey was developed by Title V staff and launched at the Specialized Pediatrics Services clinic locations including the child evaluation centers. Over 700 responses were received by families that accessed care for their children through the child evaluation centers. Responses are being entered and data is being cleaned and analyzed. It is anticipated that this end user information will be helpful in the State's review of the current child evaluation center delivery system.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network, and NJ is attempting to reverse that trend. SCHEIS is working with the American Academy of Pediatrics New Jersey Chapter Pediatrics' Pediatric Council on Research and Education's (PCORE) and the Statewide Parent Advocacy Network's (SPAN's) efforts to promote medical home initiatives developed to promote collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high-quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate.

Title V efforts to improve quality of care included continued collaboration with many partners in addressing the 6 core outcomes for CYSHCN through parent-professional medical home initiatives. Using a multi-county approach, outreach was conducted to pediatric and family practices and FQHCs throughout the southern and central regions of NJ. The SCHS CMUs provided lists of providers that routinely served CYSHCN in their caseloads, and SPAN and PCORE invited practices to "Kick Off" events providing an overview of the medical home/ISG initiative. Title V provided consultation on specialized pediatric services and case management, presented at medical home learning collaborative meetings and care coordination webinars, and provided resources to practices.

As NJ continues to collaborate with Consortium of Care partners to address the 6 core outcomes through Consortium of Care activities and improve quality of care such as medical home training and consultation with providers. Participants share updates in programs and services to facilitate appropriate referrals resulting in access to care, including Perform Care, services for CYSHCN with developmental disabilities through DCF, and the DHS Division of Developmental Disabilities. Likewise, State staffs will continue to provide technical assistance and monitoring of Title V service providers including interviews of clients that have received services. The electronic BDARS and CMRS module provides opportunities to view client referrals and service outcomes, and reinforce the SCHS CM-client interactions.

Family Centered Care Services State staffs are providing regionalized training on access to care for CYSHCN and their families, including women of childbearing years that may not know their HIV status to the Community Health Workers (CHW) engaged in the Department's Improving Pregnancy Outcomes Initiative. The CHWs report engaging with pregnant women with CYSHCN in their homes that could benefit from information shared on application for SSI, medical home, Medicaid, insurance through the Marketplace, linkage with Early Intervention Services, pre-school handicapped services, and SCHS CM.

NJ continues to work toward ensuring that a sufficient number of pediatric subspecialists are available statewide to provide high-quality tertiary care to CYSHCN and endorses the interdisciplinary team approach to comprehensive care. In addition to autism care being provided by the CECs, 6 Clinical Autism Centers have been partially funded by the Governor's Council for Medical Research and Treatment of Autism/DHSS to enhance their autism diagnostic and treatment services.

SCHEIS, through the Newborn Screening and Genetic Services Program, oversees 14 health services grants that provide partial funding for 37 specialty care programs to ensure the existence of a safety net of regional specialty agencies providing general medical genetic services, confirmatory testing of newborn screening results, and diagnosis and treatment for individuals identified with genetic disorders, cystic fibrosis, inherited endocrine defects, inherited metabolic defects, severe combined immunodeficiency, and hemoglobinopathies. Working groups have also been developed for critical congenital heart defects and lysosomal storage disorders screening and follow-up.

Access to appliances including hearing aids, braces, orthotics; and medications for the treatment of asthma/cystic fibrosis is facilitated through the SCHEIS Fee for Service program.

Given the high rate of overweight and obesity in CYSHCN, SCHEIS, by joining ShapingNJ and collaborating with other stakeholders, is currently working to draw attention to the obesity prevention needs of CYSHCN.

State FCCS staffs and health services grantees attend trainings on health care reform, NJ FamilyCare and Medicaid expansion, participate in CMS webinars, and collaborate with community-based enrollment agencies. They also educate clients and their families about the benefits of health care reform for CYSHCN and their families, and link them to enrollment counselors as appropriate. Anecdotally, the information gained through trainings was particularly of interest for uninsured parents and extended adult family members of CYSHCN.

#### **SPN #6. Reducing Teen Pregnancy**

Reducing Teen Pregnancy has been identified as a priority by several Departments including: DOH, DOE, DHS and DCF with several inter-agency initiatives developed to address this priority. Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are also far more likely to be born into families with limited educational and economic resources. SPN #6 Reducing Teen Pregnancy has been identified as a priority by many Departments including DOE, DHS and DCF with several inter-agency initiatives developed to address this priority. Although teen pregnancy and birth rates are at historic lows, there were 4,188 teen births in NJ in 2013 and the teen birth rate was 14.8 births for every 1,000 adolescent females aged 15-19 years.

Preventing teen births in NJ translates to significant savings for NJ taxpayers. The teen birth rate in NJ declined 51% between 1991 and 2010, saving taxpayers an estimated \$339 million in 2010. The total costs of teen childbearing include those sometimes incurred by the children of teen mothers (public health care insurance programs, primarily Medicaid and CHIP, increased child welfare participation, and increased risk for incarceration among adolescents or young adults) and the associated lost tax revenue due to decreased earnings and spending.

#### **SPN #7. Improving and Integrating Information Systems**

The MCH Epidemiology Program, Family Health Services and the NJDOH are all involved in multiple efforts to improve and integrate public health information systems in order to promote public health surveillance and to improve the delivery of public health services and programs. Activities are related to almost every NPMs, SPMs and NOMs. Improving and Integrating Information Systems is a significant priority for the MIEC Home Visiting Program and the Improving Pregnancy Outcomes Initiative. Improving the MCH system of care will depend on quality data from an integrated information system. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). The Bureau of Vital Statistics and Registration has involved staff from FHS and the MCH Consortia in the development of the EBC upgrade. In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry or integrated MCH information system.

### **SP #8. Smoking Prevention**

Smoking prevention has been a long-term NJDOH priority. The Five-Year Needs Assessment identified smoking prevention as a SPN from past MCH Block Grant Applications, the annual NJDOH Budget Planning process, and monitoring Healthy People 2020 objectives. Recent involvement of FHS in the NGA Improving Birth Outcomes Initiative and the IM CoIIN has increased the recognition that smoking prevention plays in improving birth outcomes, preventing prematurity and reducing infant mortality. FHS has several programs that include a smoking prevention component that could be strengthened with further collaboration with the Community Health and Wellness Service Unit.

## II.D. Linkage of State Selected Priority Needs with National Performance and Outcome Measures

NJ has selected the following National Performance Measures (NPMs) based on the State Priority Needs and the findings of the Five-Year Needs Assessment. The selected NPM will be addressed over the next five-year period of the Title V program. Over the next year Evidence-Based / Informed Strategy Measures (ESMs) will be finalized which directly impact the selected NPMs and in turn drive the improvement of NOMs.

### Performance Measures Framework from Appendix E

<b>NPM #</b>	<b>National Performance Measure (NPM) Priority Areas</b>	<b>MCH Population Domains</b>	<b>Rationale: NOMs</b>
1	Well woman care	Women/Maternal Health	1, 2, 3, 5, 6, 7, 8, 21, 22
4	Breastfeeding	Perinatal/Infant Health	1, 2, 3, 4, 5, 6, 7, 8, 9
5	Safe sleep	Perinatal/Infant Health	1, 2, 3, 4, 5, 6, 7, 8, 9
8	Physical Activity	Child and Adolescent Health	9, 11, 13
11	Medical home	Children and CSHCN	10, 11, 13, 15, 16, 17
12	Transition to Adulthood	Children and CSHCN	18, 19, 20, 23
13	Oral health	Cross Cutting/Life course	9, 14
14	Smoking	Cross Cutting/Life course	All

## II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

NJ has selected the following 5 State Performance Measures (SPMs) to address the unique MCH needs of the State. Selection of the SPMs is based on the findings of the Five-Year Needs Assessment, past MCH Block Grant Annual Applications/Reports, the monitoring Healthy People 2020 objectives process, and the annual NJDOH Budget Planning process,

### New Jersey Selected State Performance Measures:

<b>#</b>	<b>Selected State performance Measure (SPM)</b>	<b>Domain</b>	<b>Related NOM</b>
1	Black Preterm Births	Perinatal/Infant Health	1 to 9
2	Elevated Lead Screening	Child Health	9, 20, 24
3	Hearing Screening Follow-up	CSHCN	9, 19, 23, 24
4	Referral from BDARS to Case Management	CSHCN	18,19,20
5	Age Reporting Autism to DBARS	CSHCN	18, 19, 20

## **II.F. State Action Plan and Strategies by MCH Population Domain**

### **II.F.1. Introduction**

The following is NJ's Five-Year State Action Plan developed from the Five-Year Needs Assessment. This Action Plan serves as the Application/Annual Report narrative discussion for NJ on the planned activities for the Application year and the activities that were implemented in the Annual Report year. Activities will be discussed in terms of the state's targeted performance and its achievements around the NOMs, NPMs, ESMs and SPMs. The State Action Plan includes a discussion of the health status/outcome and performance measures for each of the six population health domains.

The Five-Year Action Plan, on the next page, is a tabular representation of the narrative for the Five-Year Action Plan, organized by the six population health domains and each selected NPM. For each selected NPM the related ESMs, NPMs, and NOMs represent the integrated three-tiered performance measurement system from the Logic Model.

This Table should be considered a planning tool to be used in the development of the Five-Year Action Plan that aligns the identified priority needs with the program strategies and performance measures. It is recognized that the Five-Year Action Plan Table submitted in the first Application/Annual Report year (i.e., FY 2016/FY 2014) will be considered as an interim plan, which will be further refined and completed in the second Application/Annual Report year (i.e., FY 2017/FY 2015.)

## New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM from Appendix B, Guidance page 9

<b>Domains</b> (set by HRSA)	<b>State Priority Needs</b> (states identify) based on Needs Assessment	<b>Strategies</b> (states identify)	<b>National Outcome Measures (NOMs)</b> (states select from list)	<b>National Performance Measures (NPMs)</b> (select 8 of 15 )	<b>Evidence-Based or –Informed Strategy Measures</b> (due for 2017)	<b>State Performance Measures (SPMs)</b> (states select)
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Infant Mortality; 2 Preterm-related death; 3 Neonatal Mortality; 5, 6, 7, 8, 21 Postpartum hospitalizations with severe morbidity; 22 Maternal Death	<b>#1 Well Women Care</b>	IM CoIIN recommendations, HEDIS measures, Central Intake referrals; Completed CHSs & PRAs DHS Pay4Performance, Linking Medicaid and VS data	
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	IPO; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; Surveillance (PRAMS, EBC)	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth; 9	<b>#5 Infant Safe Sleep</b>	Back to Sleep & safe sleep, no bed sharing, UID Review,	#1 Black preterm births
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	IPO; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth , 9	<b>#4 Breastfeeding</b>	Baby Friendly Initiative; mPINC MIECHV breastfeeding	#1 Black preterm births
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC, CDC) School Health	11 Overweight rate; 9 Kids in very good health; 13 Kids without insurance;	<b>#8 Physical activity</b>	CSH/WSCC activities; School Health Teams; School Health Index; Fitnessgram	#2 Elevated lead screening;

<b>Domains</b> (set by HRSA)	<b>State Priority Needs</b> (states identify) based on Needs Assessment	<b>Strategies</b> (states identify)	<b>National Outcome Measures (NOMs)</b> (states select from list)	<b>National Performance Measures (NPMs)</b> (select 8 of 15 )	<b>Evidence-Based or –Informed Strategy Measures</b> (due for 2017)	<b>State Performance Measures (SPMs)</b> (states select)
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	10, 11, 13, 15 Adolescent death 10-19; 16 MVA fatality 15-19 17 Suicide 15-19	<b>#11 Medical home,</b>	SCHS Case Management; ISPs; Medical Home Index	
5) CYSHCN and 4) Adolescent/ Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case management Services; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ	18 CSHNC receiving care in a well-functioning system; 19 % CSHCN & ASD; 20 Kids with a mental/behavioral condition who receive treatment, 23 Timely NBS+ follow-up	<b>#12 Transition</b>	CM level service reports;	#3 Hearing screening F/U; #4 Referred from BDARS to Case Management Unit; #5 Age reporting autism to BDARS;
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter	14 Kids 1-6 with cavities; 9 Kids in very good health;	<b>#13 Oral health</b>	Project REACH; Project PEDS; MIEC Home Visiting;	
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA MIEC Home Visiting SSDI, ECCS; VIP; Master Client Index Project	ALL	ALL	MIECHV Evaluation/CQI	
6) Life Course	#8 Smoking Prevention	SSDI, ECCS Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA MIEC Home Visiting	ALL	<b>#14 Household Smoking</b>	Cessation referrals; Smoking assessments (CHS & PRA); Mom's Quit Connection referrals	

### II.F.1.a. Women/Maternal Health

Improving the domain of Women's/Maternal Health is crucial to the State Priority Need of Increasing Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) related to decreasing infant mortality. The selection of NPM #1 (Well Women Visits) during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on Increasing Health Births and improving women's health across the life span. The life course approach to conceptualizing health care needs and services evolved from research documenting the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. NJ has had a long-standing emphasis on improving Women's Health and has promoted several evidence-based strategies to increase preventive medical visits including: the Improving Pregnancy Outcome Initiative, IM ColIN, MIEC Home Visiting, Fetal Infant Mortality Review, Maternal Mortality Review, and other programs to promote the Life Course Model and to increase NPM #1 (Well Women Visits).

NPM #1 - Percent of women with a past year preventive medical visit

	2009	2010	2011	2012	2013
Percent of women with a past year preventive medical visit	72.86	74.58	72.11	72.93	72.47

Data Source: Behavioral Risk Factor Surveillance System (BRFSS).

#### a. Last Year's Accomplishments

The Improving Pregnancy Outcomes (IPO) Initiative through the use of Community Health Workers and Central Intake is focused on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, low birth weight, and infant mortality. The IPO Initiative is coordinated with existing federal and state-funded initiatives including Healthy Start, Maternal Infant and Early Childhood Home Visitation, Strong Start, Title X Family Planning, Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health and Wellness Services of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

Through use of Community Health Workers and Central Intake the IPO Initiative will target limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The IPO Initiative will work to improve women's health by completing standardized Community Health Screenings for participating women including the assessment of health insurance, existing medical conditions, mental health needs, and social service needs. The IPO Initiative through case management will assure that appropriate referrals are made and tracked including medical care referrals to promote NPM #1 (Well Women Visits).

NJDOH is participating in the Infant Mortality Collaborative Improvement and Innovation Networks (IM ColIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. The IM ColIN State Team from NJ identified two priority areas - improving postpartum rates and smoking cessation. The IPO Initiative will coordinate and collaborate with a variety of community partners to implement the IM ColIN recommendations from these two focus areas.

Included in improving NPM #1 is a focus on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component for a healthy pregnancy and birth outcome because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-

related complications and conditions. Prenatal care is also an opportunity to establish contacts with the health care system and to provide general preventive visits.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care to promote NPM #1 (Well Women Visits).

The regional quality improvement activities within each of the three Maternal Child Health Consortia (MCHCs) coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the electronic birth certificate (EBC). Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through Fetal-Infant Mortality Review and Maternal Mortality Review systems, as well as analyzing data collected through the EBC. Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

#### **b. Plan for the Coming Year**

Plans for the coming year to promote NPM 1 (Well Women Care) will include the recommendations of the IM CoLIN regarding postpartum visits. The IPO Initiative with Central Intake and Community Health Workers will promote the outreach and referral of women for preventive medical visits through standardized Community Health Screenings and referrals to medical care providers. The MIEC Home Visiting Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks.

### **II.F.1.b. Perinatal/Infant Health**

The domain of Perinatal/Infant Health determines the health of a child throughout the Life Course. NJDOH has identified the State Priority Need (SPN) of Reducing Black Infant Mortality and selected the related NPMs 4 (Breastfeeding) and 5 (Infant Safe Sleep) as a result of the Five-Year Needs Assessment process. NJ has implemented several evidence-based strategies related to NPM 4 & 5 which in turn will impact on several NOMs (1, 2, 3, 4, 5, 6, 7, 8, 9). Evidence-based strategies related to NPM 4 & 5 are listed in the Logic Model.

#### **National Performance Measure 4:**

- A) Percent of infants who are ever breastfed and
- B) Percent of infants breastfed exclusively through 6 months

Promoting breastfeeding has been a long-standing priority for FHS. Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months. Breastfeeding is a cost-effective preventive intervention with far-

reaching benefits for mothers and babies and significant cost savings for health providers and employers. Breastfeeding provides superior nutrition, prevents disease and enhances infant development. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training and community support.

The Healthy People 2020 breastfeeding objectives are for 81.9% of mothers to initiate breastfeeding, for 60.6% of new mothers to continue breastfeeding until their infants are six months old, for 34.1% to breastfeed until one year, for 46.2% to exclusively breastfeed through three months, and for 25.5% to breastfeed exclusively through six months. In the [2014 Breastfeeding Report Card](#) (2011 births) from the CDC, 81.6% of NJ newborns were ever breastfed (NPM #4A); 56.2.9% breastfed at six months; 30.9% breastfed at twelve months; 39.6% exclusively breastfed at three months; and 22.3% exclusively breastfed at six months (NPM #4B). These rates are all above the rates of the previous year and continue the upward trend compared to the 2010 report (2007 births), when hospitals began making progress in implementing the World Health Organization's Ten Steps to Successful Breastfeeding.

Table NPM #4

	2007	2008	2009	2010	2011
Percent of infants who ever breastfed	72.1	75.8	80.5	77.1	81.6
Percent of infants breastfed exclusively through 6 months	10.0	11.8	14.0	13.0	22.3

**Notes** - Source – the CDC's National Immunization Survey.

[http://www.cdc.gov/breastfeeding/data/NIS\\_data/](http://www.cdc.gov/breastfeeding/data/NIS_data/)

<http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf>

#### a. Last Year's Accomplishments

FHS has supported Baby-Friendly™ designation through training, technical assistance and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding (i) and the International Code of Marketing of Breast-milk Substitutes (ii). Four NJ hospitals have earned the "Baby-Friendly" designation. Two of those hospitals were recipients of a \$10,000 mini-grant from FHS. Efforts are underway to replicate the BFH Initiative in the remaining NJ delivery hospitals and 27 more hospitals are actively working toward this certification. All 50 NJ maternity hospitals are also receiving training in promoting evidence-based breastfeeding policy and practice.

With a CDC State Public Health Actions Grant, NJDOH and the NJ Hospital Association delivered webinars and technical assistance calls to 18 hospitals and held a Mother-Baby Summit for all delivery hospitals to assist them in addressing barriers to and identifying potential solutions for implementing the Ten Steps to Successful Breastfeeding.

In 2014, FHS updated its report card, "Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report" (posted at [http://www.state.nj.us/health/fhs/professional/breastfeeding\\_report.shtml](http://www.state.nj.us/health/fhs/professional/breastfeeding_report.shtml)), with 2013 Electronic Birth Certificate data. The Report is endorsed by the NJ Chapter of the American Academy of Pediatrics (NJ-AAP) and the NJ Breastfeeding Coalition. The goal of the report is to present breastfeeding initiation as a quality of care issue and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

NJ hospitals strongly participate in the Maternity Practices in Infant Nutrition and Care (mPINC) survey, which is a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2013, 85% of 54 eligible hospitals participated in the mPINC Survey. NJ has been gradually increasing its [mPINC score](#) and has improved its state rank to 18 out of 53 in 2013.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in NJ remain low (see Chart 9 attached to Table of Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2013, exclusive breastfeeding at hospital discharge statewide was 45.0%, while any breastfeeding (exclusive and combination feeding) was 80.9% according to in-state electronic birth certificate records.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (91.8%) while black non-Hispanic women were least likely to breastfeed (67.0%). White non-Hispanic and Hispanic women initiated breastfeeding at 81.3% and 83.2% respectively.

The exclusive rates were 56.6% for white non-Hispanic women, 41.5% for Asian non-Hispanic women, 34.4% for Hispanic women, and 30.8% for black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

WIC Services provides breastfeeding promotion and support services for WIC participants through grants to all 17 local WIC agencies. International Board Certified Lactation Consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC staff conducts the *Loving Support*® Through Peer Counseling Breastfeeding Program. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the Improving Pregnancy Outcomes Initiative and the MIEC Home Visiting Program. In SFY 2013, 66.2% of mothers with 6-week-old infants participating in the MIEC Home Visiting Program were breastfeeding.

Close collaboration between Maternal and Child Health Services (MCHS), WIC Services (WIC), and Community Health and Wellness Services is ongoing. All three programs have an interest in breastfeeding protection, promotion and support and have similar constituencies.

In January 2014, the State finalized new Hospital Licensing Standards that require hospitals to develop and implement evidence-based written policies and procedures for obstetrics, perinatal and postpartum patient services, newborn care, the normal newborn nursery, and emergency departments that address breastfeeding and supporting the needs of a breastfeeding mother and child from the point of entry into the facility through discharge. These Standards support the Ten Steps to Successful Breastfeeding.

The NJDOH will call attention to NJ's second worst rate in the nation (28.4%, with a Healthy People 2020 Target of 14.2%) for hospitals supplementing breastfed infants with formula before two days of life and draw attention to the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, which required hospitals with at least 1,100 deliveries to adopt the performance measure for exclusive breastmilk feeding as of January 1, 2014.

#### **b. Plan for the Coming Year**

Efforts to promote BFHI designation through training, technical assistance, and mini-grants will continue to promote NPM 4A & B. Surveillance through the Breastfeeding Report Card and the mPINC survey will continue to identify areas of potential improvement.

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program. The CDC State Public

Health Actions Grant will continue with webinars and technical assistance calls to the 18 participating hospitals.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the IPO Initiative and the MIEC Home Visiting Program which now serve all 21 counties and targets high-need communities. A Breastfeeding indicator, increase over time in the proportion of mothers who breastfeed their 6-week-old infants, is included in the performance benchmarks.

### **National Performance Measure 5:**

Percent of infants placed to sleep on their backs

Promoting infant safe sleep was selected as NPM #5 during the Five-Year Needs Assessment process for its importance in reducing preventable infant deaths and its potential impact on improving NOMs 1, 2, 3, 4, 5, and 6. Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed and unknown causes. Due to the heightened risk of SIDS when infants are placed to sleep in side or stomach sleep positions, health experts and the American Academy of Pediatrics (AAP) have long recommended the back sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

Table NPM #5

	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Percent of infants placed to sleep on their backs</b>	57.8	60.6	61.1	64.2	61.8	65.6	65.7	67.4	68.9

**Notes** - Source – NJ PRAMS.

<http://www.cdc.gov/prams/pramstat/index.html>

#### **a. Last Year's Accomplishments**

To promote infant safe sleep, NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics, the NICHD's [Safe to Sleep](#) Campaign, the activities of the [SIDS Center of New Jersey](#), and the work of the Sudden Unexpected Infant Death Case Review ([SUID-CR](#)) Workgroup. To improve the surveillance of infant safe sleep practices, FHS conducts the PRAMS survey which includes questions on infant safe sleep and participates on the SUID-CR Workgroup.

The SIDS Center of New Jersey (SCNJ) is a program funded by the NJDOH at Robert Wood Johnson Medical School, a part of Rutgers, The State University of New Jersey, New Brunswick and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack. SCNJ was established in 1988 through the SIDS Assistance Act. The SCNJ mission is to: 1) provide public health education to reduce the risk of sudden infant death, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with sudden infant deaths, including those classified as Sudden Infant Death Syndrome.

SCNJ works with parents, grandparents, physicians, nurses, the child care community, hospitals, first responders, schools, social service agencies, health and education programs and state, federal and national organizations to reduce infant mortality and the racial and ethnic disparities associated with it.

SCNJ follows the guidelines of the AAP when providing risk reduction education. The Safe Infant Sleep guidelines of the AAP are intended to help families reduce the risks that are associated with Sudden Unexpected Infant Deaths including Sudden Infant Death Syndrome and Accidental Suffocation and Strangulation in Bed. [Research](#) conducted by the SCNJ contributed to these recommendations. Since the SCNJ was established, the rate of SIDS in New Jersey has been reduced by 75%.

NJ has participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) Registry grant funded by the CDC since 2006. SUID-CR activities have standardized and improved data collected at infant death scenes and promoted consistent case review, classification and reporting of SUID cases. NJDOH is represented on the multi-disciplinary SUID-CR Review Board which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board ([CFNFRB](#)). The SUID-CR is staffed by the Department of Children and Families and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR makes recommendations to the statewide CFNFRB concerning safe sleep and promotes SUID prevention activities.

Through the multiple evidence-based strategies in NJ to promote infant safe sleep and the consistent message to place infants to sleep on their backs, NPM #5 has been slowly improving from 57.8% in 2003 to 68.9% in 2011 according to NJ PRAMS data. The SUID rate has also declined from 0.8 per 1,000 live births in 2000 to 0.3 per 1,000 in 2012 according to the NCHS. Racial and ethnic disparities in NPM 5 persist and are being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program.

#### **b. Plan for the Coming Year**

Plans for the coming year to promote safe infant sleep include continued safe sleep education through the SIDS Center of NJ, MIEC Home Visiting Program and prevention activities of the SUID-CR grant. The SUID-CR Coordinator will be participating in the Infant Mortality CollIN sessions that focus on improving infant safe sleep practices. Evidence-based strategies proposed by the IM CollIN sessions on infant safe sleep will be considered by the SUID-CR Workgroup. Staff from the MIEC Home Visiting Program have all been trained by the SIDS Center of NJ and will promote the infant safe sleep message during their visits to over 6,000 families annually in NJ.

#### **State Performance Measure 1: *The percentage of Black non-Hispanic preterm births in NJ***

	2005	2006	2007	2008	2009	2010	2011	2012
Annual Indicator	11.5	12.1	11.3	11.0	10.6	10.0	9.9	10.0
Numerator	1,866	2,039	1,945	1,861	1,744	1,577	1,489	1,540
Denominator	16,221	16,864	17,256	16,858	16,507	15,779	14,992	15,475

**Notes** - Source of provisional 2012 data is the Electronic Birth Certificate file which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

See Chart 5 Low Birthweight by Race/Ethnicity attached to Section IV. A. Background and Overview.

The selection of SPM #1 (The percentage of Black non-Hispanic preterm births in NJ) during the Five-Year Needs Assessment process recognizes the persistence of racial/ethnic disparities in healthy birth outcomes in NJ. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative was to increase the rate of first trimester prenatal care in NJ to at

least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

#### **a. Last Year's Accomplishments**

The Department's commitment to reduce black infant mortality and preterm births has been demonstrated through the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force, the Access to Prenatal Care Initiative, the ASTHO Prematurity Pledge, the MIECHV Program, the NGA on Improving Birth Outcomes, the IM CollN, and the recent Improving Pregnancy Outcomes Initiative.

#### **b. Plan for the Coming Year**

IPO Initiatives will develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families. The goal of this IPO initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory groups for the IPO Initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems.

Thirteen grants were awarded for the Community Health Worker model. CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports. The focus of the IPO Initiative is to increase the number of women receiving preconception care as well as earlier and regular prenatal care, increase parenting education, and increase the number of women and children receiving primary care and health promotion. Seven grants were awarded for the Central Intake model which focuses on strategic efforts to assure that the specific needs of individual and families are identified and addressed effectively within community-wide service systems. Both models will be using the Perinatal Risk Assessment (PRA) and the Community Health Screening tool. The goal of risk assessment is to prevent or treat conditions associated with poor pregnancy outcome and to assure linkage to appropriate services and resources through referral.

NJDOH will continue to partner with the March of Dimes NJ Chapter in the [Healthy Babies are Worth the Wait](#), a program to reduce preterm births among African American women in Newark.

The Department's commitment to reduce black infant mortality will continue through the NGA on Improving Birth Outcomes, the IM CollN, the MIECHV Program, and the current Improving Pregnancy Outcomes Initiative.

### **II.F.1.c. Child Health**

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #8 Physical Activity and #13 Oral Health. NPMs #8 and #13 were selected during the Five-Year Needs Assessment process for their impact on overall child health and for the evidence-based strategies implemented by NJDOH and its partnerships.

#### **National Performance Measure 8:** *(see detail sheet page 81 Appendix)*

Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day

	2003	2007	2011-2012

Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	23.6	35.5	27.6
Percent of adolescents ages 12 through 17 who are physically active at least 60 minutes per day	19.0	23.0	23.2

Source – National Survey of Children's Health (NSCH)

#### a. Last Year's Accomplishments

Increasing NPM #8 is an important focus in the domain of Child Health to prevent obesity and improve overall child health and well-being. FHS has been collaborating on and developing partnerships to address this NPM thru ShapingNJ and the [Coordinated School Health](#) (CSH) program. Regular physical activity can improve the health and quality of life of Americans of all ages. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

FHS recognizes that positive physical activity and nutritional practices start at a young age and should be addressed as early as possible. Children at greatest risk for overweight and obesity as well as physical inactivity are concentrated in disadvantaged communities. NJ has had one of the highest obesity rates among low-income children 2 to 5 years of age at 16.5%, according to the 2011 WIC Pediatric Nutrition Surveillance System.

ShapingNJ continues to work with Community Health and Wellness staff and the Office of Local Public Health to accelerate the work of the ShapingNJ partnership and prioritized strategies. ShapingNJ is partnering with Nemours Foundation to sustain state obesity efforts for child care by improving the knowledge, skills and practices of child care center staff. Training and technical assistance is focused on approximately 100 licensed child care centers targeting 10,000 children in year one. With CDC funding from DP1305, child care toolkits to assist providers in improving nutrition and physical activity practices are being developed and disseminated. Additionally, DP1305 funds are supporting the modification and piloting of the Nemours curriculum for use with family child care providers.

The ShapingNJ child care workgroup has collaborated on a number of systems efforts. Child care partners continue to offer training and technical assistance at county and statewide trainings to increase center staff capacity for best practices that will prevent obesity in our most vulnerable population. Beginning in April 2013, NJ received funding from Nemours Foundation as part of a six-state early care and education learning collaborative to ensure that licensed child care providers offer children healthy food, breastfeeding support and opportunities for active play. One hundred licensed centers serving 100 or more children were enrolled. Participation in this project will assist centers meet and exceed new licensing requirements. New licensing requirements were adopted by the Office of Licensing (Department of Children and Families) and became effective September 30, 2013 (<http://www.state.nj.us/dcf/providers/licensing/laws/CCCmanual.pdf>). Sustainability efforts can be achieved through participation in a six-state early care and education learning collaborative coordinated by the Nemours Foundation and funded by CDC. A state coordinator was hired to work within the NJDOH and five regional learning collaboratives were established in NJ in year one of a five-year funding that focused on improving skills of child care center staff.

The Child Care Workgroup of ShapingNJ developed and distributed a best practices toolkit to partners at the annual ShapingNJ meeting in June 2013 and was shared with county-level partners through the Office of Local Public Health for more rapid dissemination. It is also posted on the [ShapingNJ.gov](#) website.

The work of the New Jersey Partnership for Healthy Kids (NJPHK) supports Robert Wood Johnson Foundation's (RWJF) six policy priorities for improving nutrition and increasing opportunities for physical activity, both of which are critical to reversing the childhood obesity epidemic. NJPHK is a statewide program of the RWJF with technical assistance and direction provided by the NJ YMCA State Alliance. The goal of the program is to convene, connect and empower community partnerships across the state to implement environment- and policy-changing strategies that prevent childhood obesity. Community coalitions in Camden, New Brunswick, Newark, Trenton, and Vineland are leading these efforts.

The six policy priorities are:

1. Ensure that all foods and beverages served and sold in schools meet or exceed the most recent dietary guidelines.
2. Increase access to high-quality, affordable foods through new or improved grocery stores and healthier corner stores and bodegas.
3. Increase the time, intensity and duration of physical activity during the school day and out-of school programs.
4. Increase physical activity by improving the built environment in communities.
5. Use pricing strategies – both incentives and disincentives – to promote the purchase of healthier foods.
6. Reduce youth exposure to unhealthy food marketing through regulation, policy and effective industry self-regulation.

#### **b. Plan for the Coming Year**

The partnership with Nemours Foundation will continue (funding period 2013-2018) with additional learning collaboratives being launched. Efforts will be planned to integrate this work with the work of other State Departments (Agriculture, Children and Families, Education and Human Services). Child care toolkits to assist providers in improving nutrition and physical activity practices will be disseminated.

#### **National Performance Measure 13:** (see detail sheet page 81 Appendix)

- A) Percent of women who had a dental visit during pregnancy and
- B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Oral health is a vital component of overall health. The second selected NPM in the domain of Child Health is NPM #13A (Percent of women who had a dental visit during pregnancy) and #13B (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year). Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.

Table NPM #13

	2003	2004	2005	2006	2007	2008	2009	2010	2011-
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									<b>2012</b>
Percent of women who had a dental visit during pregnancy					N/A				N/A
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year					78.7				79.9

Source – National Survey of Children's Health (NSCH)

#### a. Last Year's Accomplishments

The Children's Oral Health Program (COHP) has over a 30-year history of providing interactive, age-appropriate oral health education programs to school-age children throughout the State. During the 2013-2014 school year, approximately 80,000 students in high-risk areas where the water is not optimally fluoridated received oral health/hygiene education and oral health personal care resources. During that school year, over 15,500 students participated in the voluntary school-based fluoride mouth rinse program, "Save Our Smiles," and over 3,000 kindergarten and first-grade students participated in the Project:BRUSH initiative that engaged the school and local community with oral health messages throughout the year. Other key programs included "Sugar-Less Day to Prevent Tooth Decay" carried out in the 21 counties of the State with over 1,200 fourth-grade students participating. Efforts to target multidisciplinary obstetric, pediatric, medical, nursing and home visiting staff resulted in educating approximately 3,500 providers through train-the-trainer efforts to incorporate oral health care instruction in the patient and home visiting setting.

During 2014, the NJ Dental Clinic Directory, "Dial a Smile" was updated and distributed to over 3,500 school nurses, WIC sites, summer camps, special needs children's programs and the NJ Home Visiting Programs in efforts to assist clients in securing a dental home and increasing access to dental care services.

A variety of publications including the "Miles of Smiles" annual school newsletter was mailed to over 3,300 schools, while the "Special Smiles" newsletter was mailed to special services school districts and Special Child Health and Early Intervention Service sites. The "Oral Health Facts for Women, Infants, and Children" newsletter was provided for WIC Coordinators throughout the State.

While the overarching goal of the COHP is to improve the oral health status of school-age children through a variety of interactive oral health education programs, special initiatives are also conducted by the Program. During the 2013-2014 school year, Project: BRUSH an interactive oral health awareness campaign that promotes good oral health practices for children in grades K to 1 reached approximately 3,000 students and included the "Ask a Dental Hygienist" activity. Project "Seal in a Smile" reaching over 1,500 students was a new initiative promoting good oral health, healthy food choices and the application of dental sealants. Children received an oral health starter kit containing a parent take-home education flyer emphasizing the importance of dental sealants in the prevention of tooth decay. "Sugar-Less Day to Prevent Tooth Decay" engaged fourth-grade students, school nurses, and art and classroom teachers in themed poster contests. This successful initiative targeted approximately 1,200 students and was featured in major Statewide newspapers.

Project PEDs, "Pediatricians Preventing Early Dental Disease" continued to be implemented in select FQHC sites as a train-the-trainer model reaching over 1,600 patients. The initiative highlights the importance of engaging and educating a multidisciplinary pediatric staff regarding the importance of addressing oral health care and referral for dental services during the well child visit.

Project:REACH, "Reducing Early Childhood Caries through Access to Care and Health Education," is an oral health education initiative targeting a multidisciplinary obstetric staff in federally qualified health centers throughout the State reached over 1,580 pregnant women emphasizing the oral-systemic health

link and providing resources for dental care referral. Women receive "Oral Health Care Starter Kits" for personal and infant oral health care.

In addition, during the 2014-2015 school year, the Dental Sealant New Jersey Oral Health Survey was conducted to determine the presence of dental sealants on the molar teeth of third-grade students. Statewide estimates of dental sealants occurred in 52% of third-grade students, which was a 5% increase since the last survey was conducted. Of the 52% of students who have dental sealants, 93% of those students have dental insurance. Data also showed that 91% of third grade students had a dental exam during the past year. Of the 91% of third-grade students who had a dental exam within the last year, 93% of those students have dental insurance.

While data showed that 48% of third-grade students did not have a dental sealant, 89% of those students did have dental insurance. And of the 9% of third-grade students who did not have a dental check-up within the past year, 73% of those students have dental insurance. While significant numbers of students have dental insurance, it appears that regular dental check-ups are not viewed as a health priority.

[Medicaid's Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#) program offers comprehensive preventive child health services to all Medicaid-eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; lead poisoning screening; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. The performance on this indicator has improved greatly and according to the 2011 Annual EPSDT Participation Report.

Dental initiatives undertaken by DMAHS to promote utilization of dental services include:

Oral Health Stuffer – “Keeping Your Child’s Smile Healthy” was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman’s terms while educating the consumer on dental terms.

Dental Advisory Council - meets three times a year, but is also convened for special projects. The Council’s activities include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

Medical/Dental Directors Meetings – These meetings occur two to three times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in NJ Administrative Code (N.J.A.C.) or the HMO Contract.

Insure Kids Now Website – Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentists seeing children by HMO and State Fee for Service.

#### **b. Plans for the Coming Year**

Utilizing an evidence-based strategy approach in future years, the COHP plans to continue the implementation of the following program initiatives while also enhancing efforts that reach school-age children and pregnant women through oral health and hygiene education efforts supplemented with oral health personal care resources.

NJ has developed and implemented the “Be a Smart Mouth” oral health component for home visiting programs that was implemented in 2014. Through a Statewide effort, over 4,000 families participating in the MIECHV Program were reached and provided oral health education and personal care resources. Families were assisted in establishing a dental home and encouraged to have regular dental exams. The

Program plans to continue oral health training to staff in all NJ programs emphasizing the importance of preventive dental visits. Given the success of “Be a Smart Mouth,” this NJ Program has been shared with the Association of State and Territorial Dental Directors as a Best Practice Approach and with the National Nursing Workgroup on Oral Health. Program promotion efforts will emphasize “Be a Smart Mouth” as a cost-effective model for replication on a national level with the goal of increasing the number of first-time families who have a dental home and receive a preventive dental visit.

As an upcoming activity through collaborative efforts, the COHP plans to work with staff from the Department of Children and Families and home visiting staff from the three NJ MIECHV Home Visiting Programs to determine the following information:

1. Do you have a dentist?
2. Did you have a dental check-up in the last year? (pregnant woman)
3. Did your child have a dental check-up in the last year?

Future activities include collaboration with the pediatric dentist from a COHP grantee agency for Statewide home visitor oral health trainings.

Project REACH, (Reducing Early Childhood Caries Through Access to Care and Education) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate obstetrical staff about the importance of good oral health with the overarching goal of reducing early childhood caries through dissemination of oral health education and personal care resources for pregnant women and their children and referring them for dental services along with establishing a dental home.

Project PEDs (Pediatricians Preventing Early Dental Disease) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate pediatricians about the importance of oral health and assist them to incorporate preventive oral health education in the well child visit. Through dissemination of oral health education and personal care resources along with dental care referrals and assistance in establishing a dental home, clients will be encouraged to seek preventive dental care visits.

The NJ Dental Clinic Directory, “Dial a Smile” is a public source of information on dental clinic services in NJ. The Directory has a Statewide distribution to school nurses, hospital emergency room directors and nurse managers, summer camps directors and home visitors from the three NJ MIECHV Programs. Staff use the Directory to refer individuals for dental care services and assist them to establish a dental home. Use of the Directory helps to reduce costly hospital emergency room care for non-traumatic dental services and increases the use of the Statewide network of Federally Qualified Health Centers. The Program plans to prepare and submit a “Best Practice Report” for the Association of State and Territorial Dental Directors in addition to updating the Directory during the 2015-2016 grant year.

In aligning with the national trend to incorporate an oral health education component into nursing curriculum, the Children’s Oral Health Program will explore potential nursing school curricula and contact nursing school directors to develop an oral health education component for the classroom/clinical setting.

**State Performance Measure 2:** *The percentage of children with elevated blood lead levels ( $\geq 10$  ug/dL).*

SPM #2 was selected to address the issue of pediatric lead poisoning which is not specifically addressed by the NPMs or NOMs. Long-term exposure to lead can cause serious health problems, particularly in young kids. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from lead poisoning — their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Lead exposure can cause permanent damage to the brain and nervous system, resulting in learning, behavioral, and hearing problems, as well as slowed growth and anemia. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead

poisoning.

#### a. Last Year's Accomplishments

Meaningful progress was made toward SPM # 2 in CY 2014. More than 220,000 blood lead tests were reported on 205,483 children <17 years of age. Of the children tested during CY 2014, 83.5% were under the age of 6 years. Among these children, 0.48% had results  $\geq 10$  ug/dL and 3% had results  $\geq 5$  ug/dL. Of all the children tested, 91,501 were between six months and 26 months of age, the ages at which State regulations require children to be screened for lead poisoning. This represents 42.2% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 78% of children have had at least one blood lead test before the age of three years, and 54% of children have had at least one blood lead test before the age of 2 years.

Table SPM #2

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
<i>The percentage of *children with elevated blood lead levels (<math>\geq 10</math> ug/dL).</i>	0.7	0.6	0.5	0.5	0.5
Numerator*	1,236	1,103	898	793	820
Denominator*	185,055	182,040	183,215	176,847	171,616
Is the Data Provisional or Final?	Final	Final	Final	Final	Provisional

\*Children  $\leq 6$  years of age

**Notes** - Source: Childhood Lead Poisoning Information Database, MCHS, FHS.

The web-based data and surveillance system, LeadTrax, containing case management and environmental investigation modules continues to be customized, and remained compliant with CDC data requirements. The LeadTrax users base increased as the database was tailored to include a Healthy Homes module, HomeTrax. Strategic partnerships with home visitation and housing inspection programs enabled new users to be trained and given tiered access to HomeTrax. Efforts focused on identifying and addressing health and safety hazards where young children reside.

Ongoing efforts to increase the percentage of laboratories reporting electronically resulted in an increase from 99.24% in CY 2013 to 99.58% in CY2014. NJDOH continued to assist the remaining laboratories to transition from reporting on hard copies to electronic reporting. NJ has legislation that requires the lead screening of all children. Every primary care provider and health care facility that provides care to children less than six years of age is required to comply with the law.

Collaborative efforts with Medicaid and its contracted managed care providers continued in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning. The LeadTrax records are matched biannually to the Medicaid Eligibility file to identify lead screening rates and unscreened Medicaid participating children. The LeadTrax lead testing results are included in the NJ Immunization Information System (NJIS) to provide healthcare providers with lead screening results and histories.

Monitoring of the Elimination Plan continued to be coordinated by NJDOH to assure that the state is collectively making progress to eliminate childhood lead poisoning. In addition, a Healthy Homes Strategic Plan that was developed to expand the State's focus to other housing hazards that affect the health of all residents was implemented. Training opportunities for professionals were made available through the NJ Healthy Homes Training Center, a public-private partnership between NJDOH and Isles, Inc, a Trenton-based, non-profit, community development agency.

In New Jersey's largest city, Newark, the Newark Department of Health and Community Wellness, continued to administer the [Newark Partnership for Lead Safe Children](#). Three other local agencies continued to administer Regional Lead and Healthy Homes Coalitions with statewide outreach and a focus on primary prevention.

NJDOH is incorporating a healthy homes approach into its services provided by local health departments that provide case management and environmental intervention services for children with elevated blood lead levels. Training on healthy homes principles for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) continue. DCF's Home Visiting programs, funded in part by NJ's MIEC Home Visiting Formula Grant, provide services to pregnant women, infants, and young children. In addition, staff that assess the suitability of homes for placement of children who have entered foster care or are registered as family child care homes were targeted for training. Emphasis is placed on developing strategic partnerships with additional home visitation and government-funded home inspection agencies that serve highest-risk, hard to reach populations as identified in the Healthy Homes Strategic Plan. A CDC Cooperative Agreement, awarded in October 2014, focuses on childhood lead poisoning surveillance to determine key indicators to evaluation areas of progress and deficiencies. Through funding provided by the Social Services Block Grant, the NJDOH is providing lead and healthy homes related services as NJ continues to recovery from Superstorm Sandy. The major components are public education, professional trainings, targeted blood lead screenings and public health nurse intervention, and dust and soil sampling of highest-risk communities to identify lead hazards.

#### **b. Plan for the Coming Year**

The CDC Cooperative Agreement Year 1's outcomes will determine data-driven primary prevention interventions for the coming year that will be implemented by not only the NJDOH, but its strategic partners and lead and healthy homes grantees. Performance management strategies will be incorporated at the Program level to ensure data-driven, evidence-based practices are used. Formal evaluation of the Superstorm Sandy recovery project will be undertaken so that lessons learned can be shared throughout the state.

## **II.F.1.d. Adolescent Health**

The domain of Adolescent/Young Adult Health includes focuses on NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this combined section of both domains. This section serves as the state's narrative plan for the Application year and as the Annual Report for the reporting year. Planned activities for the Application year are described and programmatic efforts summarized that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

**National Performance Measure 11:** Percent of children with and without special health care needs having a medical home

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Providing comprehensive care to children in a medical home is the standard of pediatric practice which should be delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. State staff continues to develop refined techniques within the electronic reporting system (i.e., CMRS) that will include all seven qualities essential to medical home care.

CSHCN with a medical home has been a priority for the SCHEIS program which has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's Individualize Service Plan (ISP) developed with an SCHS CM served as a medical home proxy for 2014 reporting. It is acknowledged that a medical home is more comprehensive than just having a primary care physician. In part, it is also imperative for a child to have consistent health insurance to increase access to said provider. Of the 16,101 children age 0 to 18 years served in FFY 2014, 1,077 children (approximately 7%) had both a primary care physician and insurance identified in their ISP.

**National Performance Measure 11:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CYSHCN Survey)*

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Annual Indicator	52	40.8	40.8	40.8	40.8	38.3	38.3*		18.8
Numerator									3,019
Denominator									16,101
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Final		Provisional

**Notes** - \*Indicator data for 2006-2012 comes from the National Survey of CYSHCN, a numerator and denominator are not available. For 2014, the denominator represents all children age 0-18 years served in FFY 2014 by Special Child Health Services Case Management Units (SCHS CMU). The numerator reflects the number of children age 0-18 years who had a primary care physician service identified and/or monitored by SCHS CMU. Data reported for 2014 was retrieved from the electronic Case Management Referral System (CMRS).

**a. Last Year's Accomplishments**

All (100%) of CYSHCN referred into NJ Title V's SPSP providers and SCHS CMUs are screened for status of primary care provider and their families are provided with information on how to link with a primary care provider/medical home. The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSHCN. An 11% increase in CYSHCN served was noted across SPSP services; 54,492 (SFY 2013) verse 60,530 (SFY 2014).

Demand remains particularly high for comprehensive team evaluation, and some agencies report a 3- to 6-month wait to schedule new clients. To reverse the wait time to schedule a new comprehensive team evaluation, State staffs provide consultation to SPSP agencies. In an attempt to reduce wait time, one CEC recently implemented a pre-appointment call to families of CYSHCN that screened for presenting needs. In some instances, this technique allowed for targeted appointments with specialists rather than a full evaluation, streamlined scheduling, reduced appointment wait time to less than 6 weeks, and opened up appointments that necessitated full team evaluations in a more timely manner. Anecdotally, the agency reported that although their efforts required a slight increase in staffing time it yielded a reduced wait time, and all CYSHCN as well as their referring physicians were provided with service plans. The results of this effort were shared with other CECs, and they are exploring the possibility of replicating it. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; chart audits and visits to assess clinic days and provide consultation as well as follow-up telephone support will continue.

Likewise, family input to assess their experience with receiving specialty care through the SPSP providers was sought through a patient satisfaction survey. The survey was developed with parent and provider input, translated into Spanish, tested for cultural competency, and administered at SPSP clinic visits during December 2014. It included questions related to clinic setting/staff as well as medical care; quality of physical evaluations, receipt of clear directions on follow-up care, coordination of services and ratings on services received. Nearly 1,800 parents of CYSHCN opted to complete the anonymous self-administered survey, with 19% of responses completed in Spanish. Although some medically complex CYSHCN regularly seek treatment at SPSP clinics; i.e., Tertiary Care providers, many remain under the care of a community-based provider and seek consultation at the SPSP clinics. This collaborative treatment model requires coordination with CYSHCN's medical home. Survey findings are currently under analysis and will be reviewed by Title V staff and used in program evaluation and planning. In addition, findings will be shared with providers for use in self-evaluation. In the interim, preliminary Tertiary care survey data suggests that 70% rated their care coordination as excellent, and 77% indicated that their coordination of services is excellent. Title V anticipates that these family satisfaction findings will support future efforts to improve coordinated care and linkage with medical home.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, and the NJ AAP, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSHCN with comprehensive community providers. Building upon a Title V-funded medical home pilot project, in July 2009 Title V, in partnership with the NJ AAP and SPAN, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family-centered systems of service for children, especially children with special health care needs. This additional support for the Medical Home initiative enabled NJ AAP to work with over 30 practices in 13 counties across the State in the development of practice teams and utilization of the model for improvement to strengthen patient-centered medical homes. The ISG program success was measured using evaluation of the Medical Home Index (a nationally validated self-assessment tool for measuring "Medical Homeness" that each practice must complete pre and post-program participation). Results for participating practices showed an overall increase from pre- to post, representing an increase in their overall "Medical Homeness." For example, within Domain Six of the Medical Home Index: Quality Improvement, pre-program score for participating practices was a value of 2.4 and post-program score revealed an increase of 1.9 points for a value of 4.3. Receiving recognition for their degree or "Level" of Medical Homeness, is for many practices, the next step after participating in NJ AAP's Medical Home Initiative.

With knowledge gained through the Model for Quality Improvement and with the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Initiative, many of the practices are ready to apply for formal recognition for their efforts, with a goal of payment incentives that will support and sustain financing their Medical Homes. National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and time-consuming process with many standards and elements, including "Must Pass" elements, that busy Pediatric practices find difficult to navigate independently. Focus for Fiscal Year 2014 was to provide guidance and technical assistance to the practices that were ready to begin this recognition process.

Another example of collaboration on medical home supported by previously funded Integrated Systems Grants (ISG) with SPAN, the NJ AAP, and COCC members in 2012 targeted improvement in access to medical homes for immigrant CYSHCN and their families in three high need/limited English proficiency communities in northern NJ; Passaic, Hudson and Union counties. This project engaged Federally Qualified Health Centers, parents of CYSHCN, and family resource specialists linked with the SCHS CMUs in the above-mentioned counties to promote "medical homeness." Likewise, it promoted navigation skill development for immigrant underserved parents of CYSHCN, and leadership training. Referral to and coordination with in-State specialty care providers was also a component of technical assistance provided to private community-based pediatricians and family practitioners, hospital-based practices, and FQHCs through the ISG medical home project-

In 2014, Title V in collaboration with SPAN, the COCC, the NJ AAP, and other community-based partners, responded to a HRSA request for applications for a State Implementation Grant for Enhancing the System of Services for CYSHCN through System Integration. Although that opportunity was approved but not funded, the development of NJ's application provided an opportunity to conduct needs assessment and program planning in the area of State and community integration through medical home initiatives, and planning to integrate those improvements into MCH Block Grant activities. Title V continues to explore the challenges of how to address these plans without additional funding to support enhanced capacity, and plans for the coming year are addressed below.

In 2014, ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12. Rather than definitive identifiers for these Performance Measures, "proxies" were identified and used for this year's reporting. SCHS CMUs served 16,790 children in FFY 2014.

#### **b. Plan for the Coming Year**

Health Service grants funded by RPHS will continue to require agencies to outreach and facilitate enrollment of potentially eligible children into health insurance. The Improving Pregnancy Outcomes

Initiative will increase health insurance enrollment by assessing health insurance status and referring uninsured families with adolescents.

State SCHEIS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to Special Child Health Services Case Management Units to ensure activities related to these Measures are accurately counted.

State staffs will continue to share resources and training updates with SPSPs on the reorganization of State programs and services that can influence access to primary and specialty care, including the Comprehensive Waiver, Managed Long Term Services and Supports, and changes in access to care through implementation of the Affordable Care Act. Likewise, continuing to promote linkages between the Medicaid managed care agencies will remain important in supporting families with CYSCHN seeking in-State specialty care.

Title V will continue to support a safety net of specialty providers and case management units throughout 2015. Trends in the utilization of specialty care across the provider network will continue to be monitored by State staffs via onsite monitoring and programmatic and reports. Likewise, continued collaboration with network agencies, State agency and community-based partners through the Consortium of Care, and consumers, will continue in an effort to promote linkage for CYSHCN with a medical home.

A total of seven pediatric/family medicine practices across NJ, representing 126,500 children were recruited to participate in the AAP's Patient Centered Medical Home Technical Assistance program. The scope of Fiscal Year 2015's project will include continued evaluation of the seven participating practices' status with regard to achieving NCQA Recognition as a Patient Centered Medical Home; review and/or submission of required documentation, feedback for a series of webinars provided and progress made regarding completion of required standards during the 12-month project. The goal for 2015 is to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State.

#### National Performance Measure #06

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

**Table NPM #12:** *The percentage of adolescents (12-17) with (and without) special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Annual NPM #12 Indicator	5.8	37.9	37.9	37.9	37.9	37.9	41.8	41.8	N/A	12.2
Numerator										352
Denominator										2,892
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Final	Final		Provisional

**Notes** - Indicator data for 2005-2012 comes from the National Survey of CYSHCN, a numerator and denominator are not available (N/A). For 2014, the denominator represents all children age 12-17 years served in FFY 2014 by Special Child Health Services Case Management Units (SCHS CMU). The numerator reflects the number of children who had at least one of four transition-type services identified in their ISP.

The four possible types of transition to adulthood services identified as proxies for 2014 were:

1. identification of an adult-level primary care physician (i.e., pediatrician excluded in the current definition),
2. transition-specific services including Division of Developmental Disabilities (DDD),
3. employment, and
4. health insurance.

SCHSC CMUs serve children with special health care needs up to their 22<sup>nd</sup> birthday. When the age criterion is relaxed to include children age 12 to 21 years, 3,776 children were served in FFY 2014. Of those children, 539 children (approximately 14%) received at least one service to aid in transition to adulthood.

#### **a. Last Year's Accomplishments**

Efforts to improve documentation of transition to adulthood activities performed by SCHS CMs and documented in the electronic Case Management Referral System (CMRS) were implemented. State staffs provided technical assistance and guidance via site visits, desktop audits, and conference calls to improve the data collected and reported on transition to adulthood activities and client outcomes. Preliminary SFY 14 data are reflected in the table above.

The adolescent subset of CYSHCN served through Title V is observed to be significant. In SFY 2014, approximately 13% of CYSHCN served across the SCHS CMUs were aged 14-19 years of age. The percentage of youth age 14-19 years served by the SPSP agencies was greater, comprising nearly 25% of those served by the Tertiary Centers, and 14% by the CEC/FAS Centers. The Cleft Lip/Palate Craniofacial Centers reported 7% CYSHCN served among that same age group. Although these distributions remain fairly consistent with previous years' reporting, transition planning and implementation remained a priority for these youth, their families, NJ Title V, and providers.

Documentation of transition planning was largely noted by SCHS CMUs to occur on or about age 14. A discussion with parents/youth about transition planning, and the distribution of transition packets were noted. An anecdotal observation by the SCHS CMs noted that families reported that they preferred to receive materials incrementally rather than one very large packet filled with resources. That incremental method provided them with the opportunity to focus on one or a few transition needs at a time, such as primary care provider; access to Supplemental Security Income and/or health insurance including Medicaid, Medicaid expansion and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services' Division of Developmental Disabilities and/or the Department of Children and Family's Children's System of Care Initiative, and others. Follow-up monitoring and discussion supported family's ability to digest the material, and critically think about their needs over time.

The Specialized Pediatric Services (SPS) providers conducted evaluations and developed service plans with adolescent CYSHCN and their families. In addition, SPS providers reported providing youth with transition to adulthood resources regarding genetics, family medicine, adult providers, support groups and other medical and social related needs. The linkage of CYSHCN to multidisciplinary team members including social work and other community-based systems such as SCHS CM, SPAN, and disability-specific organizations including the Arc, Tourette's Association, and Parents' Caucus was also a strategy implemented by the SPSP agencies.

Through an agreement with SPAN, the Family WRAP (Wisdom, Resources and Parent to Parent) project provides information, resources and one-to-one family support that are directly helpful to clients. Likewise, the close working relationship with the SCHS CMUs and the SPAN Resource Parents and Parent to Parent family support offers some opportunities for cross-training on community-based resources for transition.

Linkages developed through previous ISG grants had facilitated the distribution of materials developed by SPAN, NJ AAP, NJDOH, and other community partners engaged in the COCC to medical practices. Community-based partners continued to identify resources and linkages to support transition to adulthood for CYSHCN. Likewise, training was provided to Title V providers on work incentives for persons who receive SSI or SSDI benefits, and NJ DHS' Managed Long Term Services and Supports program.

A major systems change in the redistribution of services for children and adolescents under age 16 with developmental disabilities was implemented. Access to care for those children and adolescents has been reassigned to the DCF, and they are also charged with collaboration with the Department of Education (DOE) and DHS's Division of Developmental Disabilities (DDD) to facilitate transition to adulthood services. At age 18 or high school graduation, youth/young adults' services are the responsibility of the DHS's DDD. Training on this systems change, as well as continued training on DHS' DDD and DCF's Children's System of Care Initiative affecting adolescents with developmental disabilities, is occurring with regularity among the SCHS CMUs. Collaboration with intergovernmental and community partners including DDD, DCF, NJ Council on Developmental Disabilities, Boggs Center, SPAN, the Arc, Traumatic Brain Injury Association and families is critical to appropriate access to services and supports. Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through SCHS CMUs statewide is in process as well. County-specific transition packets including resources related to education, post-secondary education, vocational rehabilitation, housing, guardianship, SSI, insurance, and Medicaid/NJ FamilyCare are shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMU's efforts to inreach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

Aligned with the Title V CYSHCN programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 1,223 were living with HIV/AIDS in 2013. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management, coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood.

However, transition to an adult program for CYSHCN is a critical decision and one that must be planned appropriately to ensure the youth remains in care. In 2013, the Title V CYSHCN program critically reviewed transition to adulthood across its community-based services, and presented a poster depicting NJ's experience at the annual AMCHP conference. Although Title V will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHS CM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences.

#### **b. Plan for the Coming Year**

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above will continue to be updated and shared with families and linkage with community-based supports is provided. State staffs will monitor the SCHS CMUs efforts to in reach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans. Likewise, efforts to capture the discussion of transition to adulthood between families of CYSHCN and SPSP providers are in process.

The SCHS CMUs and SPSP will continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the individual service plan. Likewise, exploring youth and their parents'

needs to facilitate transition with insurance, education, employment, and housing, and linking them to community-based partners will continue.

SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to NJ CDD for participation in Partners in Policymaking self-advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports. Title V will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

Under health care reform, NJ Medicaid eligibility for single adults has expanded in 2014 to up to 133% FPL. As this population is intended to include a significant percentage of childless adults with incomes below 133% of FPL, it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31). In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange.

The Arc of NJ's annual Mainstreaming Medical Care Conference has been planned for May 30, 2015. Title V participates on its Advisory Board, and the overarching theme of this year's conference is promoting medical care for persons with developmental disabilities. The integration of behavioral and medical care, work incentives for persons on SSI or SSDI benefits, and Managed Long Term Services and Supports for persons with developmental disabilities are common themes. These key concepts are vital in developing transition planning for many of NJ's CYSHCN and/or their families and SCHS CMU and SPSP providers are encouraged to attend these trainings.

## II.F.1.e. CSHCN

The population domain of CSHCN includes NPM #11 and #12 covered in the previous section and SPMs 3, 4 and 5 which impact NPMs 18, 18 and 20.

**State Performance Measure 3:** Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented.

An important SPM in the domain of CSHCN is SPM #3 (Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented) which was selected during the last Five-Year Needs Assessment.

### a. Last Year's Accomplishments

Provisional data indicates that for 2013, 82.1% of infants received follow-up after referring on inpatient screening. Since follow-up exams are still occurring on children born at the end of 2013, we expect that the rate will increase when final data is available. We anticipate the final rate will be level with prior years and will exceed the 83% target.

Table SPM #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiologic follow-up documented.

	2008	2009	2010	2011	2012	2013
Annual SPM #3 Indicator	74.5%	79.0%	85.3%	85.2%	85.7%	82.1%*
Numerator	2254	2367	2463	2471	2135	1826*
Denominator	3026	2990	2886	2899	2492*	2223*

\*Note – Data for 2013 is incomplete, follow-up reports are still being received for these children and the final rate is expected to exceed this rate.

The Early Hearing Detection and Intervention (EHDI) program is responsible for assuring newborn hearing screening goals are met, including assuring audiologic follow-up for children that did not pass initial screening. The following activities were completed in 2013 to achieve program goals:

- 1) Expanded efforts to improve screening of babies delivered at home or other out-of-hospital settings by sending a letter to families of these infants, encouraging them to bring their child to an audiologist for outpatient screening.
- 2) Participated, along with 16 other states and territories, in the National Initiative for Children's Healthcare Quality (NICHQ)/Improving Hearing Screening and Intervention Systems (IHSIS) Learning Collaborative with the aim of improving infant hearing follow-up and intervention through small tests of change.
- 3) Developed a new report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.
- 4) Co-sponsored the 5th biennial "Family Learning Conference for Families of Children who are Deaf and Hard of Hearing" on May 4, 2013 at Bergen Community College in Paramus in partnership with the Department of Human Services Division of the Deaf and Hard of Hearing, and the Statewide Parent Advocacy Network.
- 5) Completed the annual update to the NJ Pediatric Hearing Health Care Directory, a listing of audiologists, hearing aid dispensers, and otolaryngologists who provide services to young children. The Directory is available on the internet at [www.hearinghelp4kids.nj.gov](http://www.hearinghelp4kids.nj.gov).
- 6) Trained 16 new users on the EHDI reporting module in the NJ Immunization Information System (NJIIS) which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDI program receives approximately 87% of reports entered by providers through this Web-based application and the rest are sent to the program on paper forms.
- 7) Continued use of HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. During 2013 the case managers contacted 966 families.
- 8) Continued use of HRSA EHDI grant funding for one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to provide two part-time consultants who specialize in working with children with hearing loss. They have an initial phone conversation with parents of children who have recently been diagnosed with hearing loss to review EI services and discuss communication options for children with hearing loss. The consultants participate in the initial early intervention family meetings via remote access, using laptops with web-cameras. The consultants served a total of 127 families during the year.
- 9) Conducted conference calls with all 54 hospitals in NJ with maternity services to review each hospital's EHDI procedures, performance, and compliance with regulations.
- 10) Continued quarterly distribution to hospitals of report detailing children still in need of additional audiologic follow-up after not passing inpatient hearing screening. Semi-annual reports also include statistics comparing the hospital to statewide averages.
- 11) Presented information in multiple formats including conference calls, webinars, and in-person presentations on a variety of EHDI-related subjects to varied audiences which included parent support staff, audiologists, and hospital birth certificate clerks.

The EHDI program provided organizational support to New Jersey Hands & Voices. Hands & Voices is a national organization that provides parent support to families with children with hearing loss. The NJ chapter obtained full chapter status during 2013.

The Bureau of Vital Statistics and Registration will implement a new Electronic Birth Registration system, known as the Vital Information Platform (VIP), during 2014. The EHDI program will work to ensure the continued capture of inpatient hearing screening results and risk indicators via the new system. Reports routinely generated by the EHDI program, such as hospital-specific statistics and audiology facility reports, will be reprogrammed to adjust to the changed data elements captured in the new system.

The EHDI program will spread the utilization of interventions found through the NICHQ IHSIS Learning Collaborative to be effective at improving outcomes. A Quality Improvement Stakeholder team, composed largely of the NICHQ collaborative team members, will convene and hold regular meetings to review data and implement small tests of change via the PDSA cycle to identify successful strategies to achieve EHDI goals.

EHDI staff will provide educational presentations to hospital staff, pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

#### **b. Plan for the Coming Year**

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semiannually, and in intervening quarters, hospital contacts receive a list of children who are still in need of follow-up after missed or referred inpatient hearing screening.

The program will continue annual distribution of audiology facility reports to highlight timeliness of follow-up and identify children with incomplete follow-up testing.

The program will continue the grant-supported activities noted above including case management outreach to families in need of hearing follow-up and support by the EI hearing consultants, pending continued availability of grant funds.

EHDI staff will provide educational presentations to hospital staff, pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

**State Performance Measure 4:** Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

This SPM was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning, research, and to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with all defects. Starting in 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in 2009, the

Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system refers all living children and their families to our SCHS Case Management Units. The newly implemented case management module will monitor the progression into the service stream.

#### a. Last Year's Accomplishments

NJ has been very successful in linking children registered with the Birth Defects Registry (BDR) (also known as the Special Child Health Services Registry) with services offered through our county-based Special Child Health Services Case Management Units (CMUs). However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, a second module was added to the BDARS in 2012. This module will be used by the CMUs to track and monitor services provided to the children and their families. It will electronically notify a CMU when a child living within their jurisdiction has been registered. Also included in the module is the ability to create and modify an Individual Family Service Plan, track services and service providers for each child, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

**State Performance Measure 6:** Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

	2009	2010	2011	2012	2013	2014
Annual Indicator SPM #6				36	50	N/A
Numerator				1747	3508	
Denominator				4875	7047	

Note: Above 2012 data was based upon the time period of February – September 2012 due to implementing the Case Management Module in January 2012. The numerator reflects all children whose records contain an ISP objective begin date or perform date within the FFY 2013 (2674) or were referred to the Early Intervention Program (432) or whose records indicated that the child's goals were achieved, but there was no record of any services (402). The denominator reflects the number of children referred from the BDARS (7047). There also were 471 children whose case status were active, but had no record of any services. There were 1,452 children whose families did not respond to any contact attempt by the Case Management Unit.

The Case Management Module of the BDARS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child in gaining access to appropriate health and education services.

In 2013, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance system. Rutgers, Bloustein Center for Survey Research (BCSR) continued the deployment of the new Case Management Module for the BDARS. During and after deployment, the BCSR continued to work with staff from both the EIM Program and the SCHS county-based CMUs to identify and correct issues in the case tracking and management component of the BDARS. The BCSR also began development work on an Exceptional Events Module. This module will measure the impact of exceptional events, such as Superstorm Sandy, unemployment, homelessness, etc., on children with special health care needs.

The Pulse Oximetry Module continues to collect information on children who failed their newborn pulse oximetry screening test, which is used to identify children at risk for critical congenital heart defects (CCHD), which may not be apparent at birth. New Jersey is the first state in the nation to integrate the CCHD screening with their birth defects registry. Each month EIM Program staff review information from the Pulse Oximetry Module to determine the final diagnosis of a child who failed the screening test. This review involves determining whether the child has been diagnosed with a CCHD by reviewing BDARS registrations and contacting the hospital that performed the screening test.

BDR staff continued to provide training to birthing facilities, autism centers, and CMUs in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system.

In 2013, the SCHS Registry:

- Processed registrations for nearly 7,700 new children with birth defects and other special health needs,
- Referred over 7,000 families to the SCHS CMUs, and
- Received nearly 1,700 new autism-related registrations, excluding anonymous registrations.

BDR staff continues to collaborate with staff from the Family Centered Care Services Program (FCCS) and BCSR to identify and correct issues related to the BDARS and the Case Management Module to improve its ease of use and efficiency. In 2014, CDC continues to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. The BCSR will continue making improvements to the BDARS, the Case Management and Pulse Oximetry Modules, and the development of the Exceptional Events Module. The BDR staff will continue to work with the hospitals and other agencies to ensure complete reporting, especially with the birthing hospitals to ensure all children who failed their pulse oximetry screening test are reported through the BDARS.

Site visits will be conducted in each of NJ's birthing hospitals to audit their reporting through the BDARS. In addition, BDR staff will be reviewing the CMUs' performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDR and FCCS. The BDR staff will continue to identify non-traditional reporting sources, e.g., FQHC, as a means to ensure all families with special health care needs children will be identified and referred to the appropriate CMU for services.

#### **b. Plan for the Coming Year**

In 2015, CDC funding is expected to continue to assist the Program in making improvements to the Birth Defects Surveillance System. The BCSR will continue the making improvements to the Birth Defects & Autism Reporting System (BDARS) and its Case Management, Pulse Oximetry, and Exceptional Events Module to improve their ease of operation and efficiency.

BDR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, Case Management Units, and other agencies in the use of the electronic BDARS and its modules. Staff will continue to monitor the use of the electronic BDARS, especially the Case Management Module, and will assist reporting agencies and CM Units with concerns. In addition, BDR staff will continue to review the quality of the data in the BDARS and its modules.

Site visits will be conducted in each of NJ's birthing hospitals and County Case Management Units to ensure proper usage of the new BDARS and its Case Management Module. BDR and FCCS staff also will be reviewing the CMUs' performance in linking referred families to services. Units having the lowest levels of linking families to services will receive remedial assistance from staff of the BDARS and FCCS.

BDR staff will continue to work with the agencies to ensure complete and appropriate referral to services. BDR staff also will be working with non-traditional reporting sources, e.g., FQHCs, and facilities from bordering states to register children with birth defects and/or special health care needs. Building upon information visits conducted in FFY 2013, Federally Qualified Health Centers will be encouraged to report children diagnosed in their facilities.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics.

**State Performance Measure 5:** Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

	2009	2010	2011	2012	2013	2014
Annual Indicator SPM #5	4.4 years	4.2	4.6	4.7	4.8	N/A

Notes - Data has not yet been subject to quality assurance reviews.

**a. Last Year's Accomplishments**

This SPM was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an autism spectrum disorder of children reported to the NJ Autism Registry is 4.8 years old. Although there is no timeline for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the autism spectrum disorders so that families can be linked to SCHS Case Management.

While the causes of autism are not known, genetic and environmental factors are individually and in combination believed to have contributing roles. While there is no cure for autism, there are indications that a child's speech and cognitive development can be improved with early and intensive intervention. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention. In NJ, the average age of initial diagnosis of an autism spectrum disorder of children reported to the registry decreased from 4.4 years old in 2009 to 4.2 in 2010. We believe this is due to our work with the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center grant program, which increased the number of diagnostic evaluations conducted during the grant months. Unfortunately, funding for these clinical centers ended in the early part of 2011, thus potentially affecting the timeliness of new diagnostic evaluations as seen in the slight increase of age of first diagnosis in 2011 and 2012. The increase in age over time may also be a result of increases in the diagnostic and registering of children with Asperger's syndrome, which is typically diagnosed later than autistic disorder or pervasive developmental disorder-not otherwise specified.

In order for this performance measure to be accurately determined, patients with autism in NJ need to be reported to the Autism Registry by licensed health care providers who have either diagnosed them or are providing follow-up care and have the full information regarding the child's date of first diagnosis. BDARS staff has have conducted outreach to educate and inform physicians and health facilities about the registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally they have trained staff from many several private pediatric practices that are part of the Advocate health insurance network. Registry staff have also trained several psychiatric/behavioral departments located within hospitals, including the pediatric clinics at Meadowlands Hospital and Newark Beth Israel Medical Center. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS. Staff continues to conduct mailings to facilities, providers, organizations, and stakeholders who diagnose or treat children with autism, and continue to send out mailings and conduct follow-up calls on a periodic basis to newly identified providers. Staff has also created materials for both providers and families about autism. These include an autism website and conference presentations and exhibits.

NJDOH has also addressed this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities (UCEDD), in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention. In addition, the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center has funded additional clinical centers in their pursuit to create a NJ Autism Center of Excellence (NJACE).

In FY 2013, over 1,800 children were newly reported to the BDARS including all children with a diagnosis of autistic disorder, Asperger's syndrome, or pervasive developmental disorder and who had information about the date of first diagnosis. Staff has stressed the importance of quickly reporting children diagnosed as having autism by continuing to provide outreach about the Autism Registry through conference presentations and focused meetings. Staff participated in several exhibits including the Annual School Health Conference sponsored by the NJ Chapter of the AAP and have presented to a number of private pediatric offices throughout NJ. Staff continues to send out mailings on a periodic basis to newly identified providers and have recently deployed a new Autism Registry webpage ([http://www.state.nj.us/health/fhs/sch/autism\\_registry.shtml](http://www.state.nj.us/health/fhs/sch/autism_registry.shtml)) which will include information for parents, providers, and researchers.

Providers with untimely reporting were contacted and reminded of the mandate to report and of the importance of the linkage to SCHS CMUs. The electronic reporting component of the BDARS facilitated timelier reporting by facilities and since the BDARS added the SCHS CMU component, referral of these children to services is significantly faster. A specific target for this current year was conducting our first annual audit of autism reporting facilities in conjunction with the Birth Defects quality assurance audits.

#### **b. Plan for the Coming Year**

NJDOH will continue to focus on the importance of early identification of autism. Registry outreach efforts will continue with harder-to-reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education. Providers with less timely reporting to the Registry will continue to be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS will allow for an electronic assessment of referral rates. Registry staff will be able to use these reports to monitor timeliness as well as numbers.

The NJDOH is committed to continuing efforts to reduce the age of the first diagnosis to of autism. The Governor's Council for Medical Research and Treatment of Autism will continue to fund new grantees in their efforts of early identification of autism in children. Additionally, Early Intervention Services will continue their efforts with such providers as speech pathologists, occupational therapists and so forth who will act as a basis for early referral of children at risk for autism.

Autism Registry staff will also be working with the director of the Governor's Council on Medical Research and Treatment of Autism coordinating center to hold two or three workshops for autism diagnosticians regarding the impact of the diagnostic criteria changes from the DSM4 to the DSM5.

### **II.F.1.f. Cross-cutting or Life**

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and SPM #8 Smoking Prevention and the NPM #14 Household Smoking. SPN #8 was added as a SPN recognizing the adverse impact of smoking on all population domains and many NPMs and NOMs.

#### **National Performance Measure 14:**

- A) Percent of women who smoke during pregnancy and
- B) Percent of children who live in households where someone smokes

Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General's Report. Unfortunately, millions (more than 60%) of children are exposed to secondhand smoke in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS).

As a result of the many health consequences, the health costs from smoking in pregnancy are significant. The excess costs for prenatal care and complicated births among pregnant women who smoke exceed \$4 billion a year. It has been estimated that a 1% drop in rates of smoking among pregnant women could result in a savings to the US of \$21 million in direct medical costs in the first year. Another \$572 million in direct costs could be saved if the rates continued to drop by 1% a year over seven years. Secondhand smoke also has significant health effects on an infant. Pregnant women exposed to secondhand smoke have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke exposure also increases the risk for infections in the infant, and even death from SIDS. Children living with smokers are also more likely to get asthma attacks, ear infections, and serious respiratory illnesses like pneumonia and bronchitis due to secondhand smoke. The cost to care for childhood illnesses resulting from exposure to secondhand smoke is estimated at \$8 billion a year. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from directly smoking or from a secondhand exposure) are well documented in the literature and include respiratory infections and disease, cancer, and death.

#### Tables NPM 14A & B:

##### A) Percent of women who smoke during pregnancy

	2003	2004	2005	2006	2007	2008	2009	2010	2011
14 A. Percent of women who smoke during pregnancy	16.6	16.7	16.2	15.0	14.1	15.8	19.3	18.1	17.1

**Notes** - Data is from the NJ PRAMS Survey and the CDC Ponder System.

See NJ PRAMS Brief on Smoking and Pregnancy in NJ at

[http://www.state.nj.us/health/fhs/documents/brief\\_smoking\\_prevalence.pdf](http://www.state.nj.us/health/fhs/documents/brief_smoking_prevalence.pdf)

##### B) Percent of children who live in households where someone smokes

Annual Objective and Performance Data	2003	2007	2011-2012
14B. Percent of children who live in households where someone smokes	28.7	19.7	20.3

Data Source: National Survey of Children's Health (NSCH)

#### a. Last Year's Accomplishments

Initiated in 2001 with funding from the NJDHSS-Comprehensive Tobacco Control Program, Mom's Quit Connection (MQC) is NJ's maternal child health smoking cessation program. There have been changes in the services provided and their capacity to be a statewide program through the years based on availability of funds. MQC's trained Tobacco Dependence Specialists utilize a proactive behavior modification model, offering face-to-face individual counseling at the referring health care facility, onsite group counseling or telephone counseling to assist clients in developing a customized quit plan. From July 1, 2013 - June 29, 2014, there were a total 504 referrals to MQC case management: 274 were fax referrals, 32 were self-referrals, and 198 were referred through the PRA system. Of the 139 open MQC clients for this grant year, 70.5% either decreased their consumption or quit smoking. During that same time 72 face-to-face intakes were completed and 37 telephonic intakes were completed. A total of 2,440

client contacts were made through phone, email, in person or mail. During this year, 106 clients received a total of 380 sessions: 200 sessions were face-to-face and 180 were telephone sessions.

The program was expanded during FY 2015 and Mom's Quit Connection (MQC) was able to develop a multi-pronged and comprehensive statewide approach to perinatal smoking cessation activities. The new activities include:

- Promoting Mom's Quit Connection (MQC) in order to further expand its reach to pregnant and parenting mothers in New Jersey.
- Increasing capacity of Mom's Quit Connection with respect to direct services for pregnant and parenting mothers statewide.
- Preventing relapse after delivery.

MQC provides free onsite Ask, Advise, and Refer Brief Intervention training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the fax to quit referral process and ongoing cessation support as a routine component of care. In FY 2014, there were a total of 40 educational programs on the dangers of smoking and the risks of exposing children to secondhand and thirdhand smoke with 1,178 participants for this grant year. Staff conducted 31 Ask, Advise, and Refer: Brief Intervention trainings to a total of 284 professionals.

#### **b. Plan for the Coming Year**

Plans for the upcoming year to address NPM #14 include:

Promoting Mom's Quit Connection (MQC) to expand reach to pregnant and parenting mothers in NJ;

- Train prenatal health care providers to screen and refer smoking adolescent and adult patients (with a specific focus on pregnant/postpartum mothers).
- Train statewide prenatal providers to generate an automatic electronic referral for pregnant smokers identified during the Perinatal Risk Assessment (PRA) process. The Southern New Jersey Perinatal Cooperative is currently piloting PRA electronic referral to MQC in four pilot sites in the South. PRA is being used more and more frequently in the state and an automatic referral would increase the reach of MQC across NJ.
- Conduct an extensive public awareness campaign re availability of MQC for pregnant women who smoke. Use no-cost and low-cost television and radio advertisements, many of which are available from the Centers for Disease Control and Prevention.

Increasing Capacity for Direct Service in NJ;

- Continue to expand MQC's existing services to enable face-to-face counseling in the Northern and Central regions of the state, handle increased volume of calls and requests for face-to-face counseling resulting from outreach activities, and expand activities into the postpartum period to decrease the likelihood of relapse.
- While MQC does not currently turn away postpartum women, because of limited funding, they do not actively outreach to or offer programming specifically for postpartum women. Because of the high relapse rate in postpartum women, it is essential to expand programming to address this population's needs.

Preventing relapse after delivery;

- Develop Pregnant Smoker to Stay Quit Mom interactive online app and social networking site to connect women with cessation services, provide mechanism for registering/intake survey, offer stay quit support (e.g, online chat groups for parenting moms), and provide targeted and general cessation information.
- Develop a personalized quit plan using the newly developed online app and send personalized Text to Quit messages to pregnant women and new mothers.

Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Adolescent smoking and smokeless tobacco use are the first steps in a preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Current cigarette use among NJ high school students declined sharply during 1997–2003; however, rates have remained relatively stable over the past several years.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs. However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco-caused disease, death and disability.

## **II.F.2. MCH Workforce Development and Capacity**

MCH workforce development and capacity are a priority for the NJDOH Division of Family Health Services (FHS). Without an adequately trained MCH staff vital Title V services and functions would not be provided to meet the needs of the MCH population. Recognizing the value of an experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

The FHS implemented the development of succession planning to assure essential functions were considered in long-term planning. Cross-training of staff was implemented to assure the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V have been quite minimal, reflecting the long-standing MCH priorities and core functions of staff.

Critical workforce developmental and training needs of state Title V staff have included training in continuous quality improvement and cultural competency. Available opportunities have been pursued through trainings offered at national conferences including AMCHP, the [MCH Epidemiology Conference](#), and the [MCH Public Health Leadership Institute](#). Departmental trainings have been offered on Ethics training, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs and state assignees have also been successful.

## **II.F.3. Family/Consumer Partnership**

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping NJ to achieve its MCH outcomes. FHS has several initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of New Jersey's Title V program.

Efforts to support Family/Consumer Partnerships, including family/consumer engagement, are in the following strategies and activities:

- Advisory Committees;
- Strategic and Program Planning;
- Quality Improvement;
- Workforce Development;
- Block Grant Development and Review;
- Materials Development; and
- Advocacy.

Domain	Priority	Advisory Committees	Strategic and Program Planning	Quality Improvement	Workforce Development	Block Grant Development and Review	Materials Development	Advocacy
1) Maternal/ Women's Health	#1 Increasing Healthy Births,	IPO Advisory Committees, Central Intake Advisory Committees	IM CollN, NGA	IPO Evaluation	IPO Training & Technical Assistance			
2) Perinatal/ Infant Health	#2 Reducing Black Infant Mortality,	IPO Advisory Committees, Central Intake Advisory Committees	IM CollN, NGA	IPO Evaluation				
3) Child Health	#3 Improving Nutrition & Physical Activity							
4) Adolescent/ Young Adult Health	Reducing Teen Pregnancy							
5) CYSHCN	Improving Access to Quality Care for CYSHCN	FAS Taskforce Cleft Lip/Palate Federation CEC Federation COCC SCHS CM Association	Annual planning in preparation for MCHB Public and/or provider input through family satisfaction surveys	Quarterly and annual programmatic & fiscal monitoring Annual review &/or revision of health service grant Attachment C	AMCHP scholars programs, Quarterly SCHS CM meetings/trainings on statewide systems and programs with parents and providers across FCCS invited, SPAN trainings on local, state, and national topics related to family support, transition, etc. for CYSHCN, NJ AAP medical home trainings,	Annual public and/or provider input; hardcopy &/or public testimony	All surveys, brochures, &/or educational materials developed with family input and tested for cultural competency	Parents educated on self-advocacy through SPAN-Family Voices, NJ AAP, and/or mailings of materials from State, federal, and or disease specific organizations, Title V participation in NJ CDD Partners in Policy Making mock hearings for parents and guardians of CYSHCN & self-advocates

					DOH-Human Resources Development Institute trainings on HIPAA, cultural competency, etc., CityMatch webinars			
6) Life Course	Improving & Integrating Information Systems							

#### **II.F.4. Health Reform**

National health care reform has been one of many changes impacting the role of FHS as NJ's Title V agency. FHS has positioned itself to play an important role in health systems development. FHS had long ago shifted from a direct service delivery orientation to a preventive, population-based assurance role that could be responsive to new national programs and policies and the changing economic climate.

The Patient Protection and Affordable Care Act (ACA) presents an opportunity for state maternal and child health (MCH) programs and their partners to improve the health care delivery system overall, promote health and assure that women, children and families have access to quality health care. The scope and impact of many of these provisions included in the ACA will unfold over the coming years.

#### **II.F.5. Emerging Issues**

Emerging MCH Issues have been included in the State Action Plan narrative and include Obesity, Nutrition, Autism and Improving and Integrating Information Systems. These issues have been considered emerging issues for several years and their importance recognized by State Priority Needs and State Performance Measures.

#### **II.F.6. Public Input**

The 2014 MCH Block Grant Public Hearing was held on June 17, 2014 from 9:30 AM to 12:00 PM at the New Jersey State House Conference Room number 6. Dr. Gloria Rodriguez, Assistant Commissioner, Division of Family Health Services, Dr. Marilyn Gorney-Daley, Director of Special Child Health and Early Intervention Services, and Ms. Pauline Lisciotto, Program Manager for Family Centered Care Services presided over the hearing as Panel Members. There were 10 scheduled presenters which included mostly families. Some family members, not scheduled, came to observe and give support. One mother in particular, who had not been scheduled, had traveled over an hour and missed work to hear the presentations and share written testimony. All of the testimonies expressed strong support for the 2015 MCH Block Grant Application to the US DHHS. Testimony from the Statewide Parent Advocacy Network (SPAN) and Family Voices – New Jersey (FV-NJ) spoke to the value of the partnership of SPAN and FV-NJ and the NJDOH have had in a variety of initiatives impacting children and youth with special health care needs (CYSHCN). Many families spoke in support of the services and resources provided through SPAN and Special Child Health Case Management. The value of assistance in navigating care systems for CYSHCN was also highlighted. SPAN also shared testimonies given in response to the 2014 Conference for Fathers of Children with Special Needs; this conference received an extremely positive response from attendees. Separately, three letters of written testimony in support of the MCH Block Grant application were received by FHS.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Sections II.B.2.c. and II.F.3.